HEALTH WEALTH CAREER

PCMH+ WAVE 2 COMPLIANCE REVIEW

UNITED COMMUNITY AND FAMILY SERVICES, INC.

MAY, 2019

State of Connecticut

TABLE OF CONTENTS

1 INTRODUCTION

The Person Centered Medical Home Plus (PCMH+) program was launched on January 1, 2017 as part of the Connecticut Department of Social Services (DSS) investment in value-based purchasing care coordination. PCMH+ provides person-centered, comprehensive coordinated care to HUSKY members. PCMH+ builds on the success of Connecticut Medicaid's Person-Centered Medical Home (PCMH) program which works to improve quality of care and the overall health of HUSKY members. PCMH+ Wave 2 launched on April 1, 2018 after the successful completion of Wave 1. PCMH+ Wave 2 will build on both the existing PCMH program and PCMH+ Wave 1 by focusing on Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, provider competencies to support Medicaid members with complex medical conditions and disability needs, and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits. DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the PCMH+ program and conduct reviews of PCMH+ Participating Entities (PEs).

PCMH+ is a shared savings model where PEs that meet identified benchmarks on quality performance standards and under-service prevention requirements, while reducing Medicaid expenditures and improve HUSKY member health outcomes may share in a portion of program savings. Quality measure scoring and PCMH+ program savings calculations for Wave 2 will be conducted in Fall 2019 and, therefore, are not evaluated as part of this PCMH+ compliance review. This review focuses solely on evaluating PCMH+ PE compliance with PCMH+ Wave 2 program requirements, identifying best practices and opportunities for improvement.

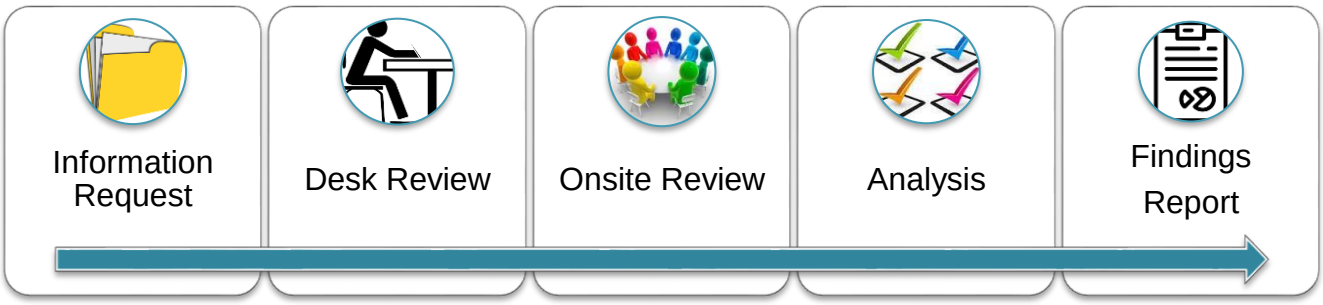
PCMH+ PROGRAM REQUIREMENTS

The PCMH+ program provides care coordination services to all PCMH+ assigned members through a set of required Enhanced Care Coordination interventions. For PEs that are Federally Qualified Health Centers (FQHC), there are additional “Add-On Care Coordination” requirements that further drive behavioral health (BH) integration within the practice. The following table provides a high-level summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are located in Section 3.

PROGRAM OPERATIONS	ENHANCED CARE COORDINATION	COMMUNITY LINKAGES
• Current participant in DSS' PCMH program • Operate an oversight body with substantial participation by PCMH+ members • Identify a PCMH+ senior leader and clinical director • Employ sufficient and qualified staff to provide enhanced care coordination services • Submit monthly reporting to DSS • Develop a planned approach to monitor, identify and address under-service	• Physical Health (PH)–BH Integration • Children and Youth with Special Health Care Needs (CYSHCN) • Competencies in Care for Individuals with Disabilities • Cultural Competency	• Implement or enhance contractual relationships or informal partnerships with community partners to impact social determinants of health (SDoH) • Sponsor local community collaborative forums or participate in existing forums • Demonstrate results of engaging in partnerships with community partners

REVIEW METHODOLOGY

The PCMH+ Wave 2 compliance review assessed for compliance, quality and effectiveness in achieving the goals of the PCMH+ program for the period between June 2018 to February 2019 and was organized into five phases presented in the diagram below:



Information Request — January 2019

Mercer submitted an information request to each PE in January 2019. The information request solicited a variety of documents and materials in an effort to gain an understanding of PE's program compliance, operations, and approach in implementation of PCMH+. The information request included but was not limited to member files, organizational charts, PCMH+ staffing, policies and procedures, narrative responses, underservice policy, and other relevant information related to the implementation of the PCMH+ program. PEs were also asked to compete a program questionnaire.

Desk Review — February 2019

Mercer received information electronically from the PEs and conducted a desk review of all submitted material. Areas where Mercer could not determine if a process or procedure was compliant with PCMH+ program standards were noted for follow-up discussion during onsite review.

Onsite Review — March 13, 2019

The onsite review for United Community and Family Services (UCFS) took place on March 13, 2019, at their 47 Town Street, Norwich, Connecticut office. The onsite review began with an introductory session with the DSS staff, the Mercer team and UCFS leadership and PCMH+ dedicated staff. As part of the introduction, UCFS presented a PCMH+ program implementation overview. Mercer and DSS conducted interviews with UCFS staff focusing on: PCMH+ Program Operations, Enhanced Care Coordination, Community Linkages, and Member Interviews. UCFS staff interviews included:

- Jennifer Granger, CEO
- Cara West Cott, COO
- Ramindra Walia, CMO
- Jim Gregware, VP of IT
- Deberey Hinchey, VP of BHS
- Yolanda Bowes, Director of Operations
- Sharon Laliberte, Compliance Officer
- Heidi Simmons, Griswold Practice Manager
- Michelle Wiik, Practice Manager
- Ellen Ross, Director, Program Evaluation/Data Management
- Brianna Chaput, Supervisor, Community Outreach
- Nancy Holte, Quality Improvement Nurse Manager
- Alecia Fontaine, PCMH Nurse Care Manager, Griswold and Plainfield
- Lindsey Wetherell, PCMH Nurse Care Manager
- Alexandra Garvey, Embedded Primary Care SW/Behavioral Health Care Coordinator

- Emily O'Hearn, Operations Administrator
- Tammy Dickson, Case Manager
- Holly Kelley, Case Manager
- Patti Passmore, Medical Home Care Coordinator
- Melissa Miller, TVCCA Case Manager

Analysis and Findings Report — May 2019

During all phases of the Wave 2 onsite compliance review, information was gathered and a comprehensive review was completed. Results of the comprehensive review is the basis for this report.

2
SUMMARY OF FINDINGS

UNITED COMMUNITY AND FAMILY SERVICES, INC. PCMH+ PROGRAM OVERVIEW

UCFS is a FQHC serving members in Norwich, Griswold and Plainfield, Connecticut. UCFS operates 17 unique sites; three of which serve the PCMH+ population. UCFS has held National Committee on Quality Assurance (NCQA) PCMH recognition since 2011. UCFS provides an array of primary care and specialist care to its members including: BH, Medication Assisted Therapy (MAT), dental, women's health, geriatric and pediatric and well child services. Additional services offered by UCFS include social services, an in-school dental program, five school-based health centers and Autism services.

Staffing for PCMH+ includes five care coordinators, including a BH care coordinator and one care coordinator dedicated to CYSHCN. UCFS also contracts with a case manager who handles SDoH issues. Other roles providing care coordination are two insurance enrollment specialists, a referral coordinator, two nurse educators, as well as medical assistants and general adult and pediatric nursing staff. UCFS also contracts with case management staff from Thames Valley Council for Community Action (TVCCA) CONNECT to help members access programs that address SDoH. The staff also assist with preparation of new DSS applications for eligibility determination and re-determination. TVCCA staff are located onsite at the Norwich Health Center, and travel to the Griswold and Plainfield offices as needed.

The Chief Operating Officer and Chief Medical Officer provide executive oversight of the PCMH+ program and report to the President & CEO. Oversight bodies include the Consumer Advisory Board and PCMH+ Steering Committee. The Consumer Advisory Board reports to the Board of Directors and includes two PCMH+ members. The PCMH+ Steering Committee includes the CEO, outpatient leadership team, PCMH+ implementation team and data review team.

UCFS provides care coordination for 6,123 PCMH+ members. UCFS reports an average penetration rate of less than 1%. The penetration rate is based on the number of unique member contacts per month divided by the assigned PCMH+ membership. Since the start of Wave 2, UCFS has reported the following unique member contacts per month: June 2018: 37 members; July 2018: 43 members; August 2018: 51 members; September 2018: 40 members; October 2018: 37 members; November 2018: 40 members; December 2018: 44 members and January 2019: 58 members. UCFS care coordinators average 8.4 care coordination contacts per month. It is important to note that a ramp-up period is typical for newly implemented programs.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	UCFS is using a risk stratification scoring strategy that includes time spent with a provider. This will help identify members needing adjusted appointment times.
Physical Health-Behavioral Health Integration	Three Peer Recovery coaches (SUD peers) have been hired to work specifically with MAT clients.
	UCFS has implemented myStrength, an evidence-based digital application, as their recovery-based tool.
	UCFS's definition of Transition Age Youth is inclusive and recognizes the particular challenges of youth with BH, PH or other challenges.
	In order to address the unique needs of BH members, UCFS asks additional questions regarding specific cultural needs and preferences.
Children and Youth with Special Health Care Needs	UCFS has added a bilingual care coordinator and another care coordinator dedicated specifically to CYSHCN to the team.
	UCFS is the Eastern Region contractor for the Department of Health's (DPH) Connecticut Medical Home Initiative (CMHI) since 2007.
	The CMHI screener and complexity index tool is used during annual physical exams to identify children who may have special health care needs.
	The PE offers notable autism-focused conveniences such as serving individuals of all ages with autism, developing an autism/neurodevelopmental program, and providing an autism-friendly dental treatment room specifically for members needing a quieter environment.
	UCFS has an established process in place for advanced care planning for CYSHCN.
	UCFS provides a binder to CYSHCN and families to organize materials such as evaluations, IEP/504 Plans, medication lists, provider contact information, plans of care and emergency care plans.
	The PE has strong processes in place which emphasize the relationship between CYSHCN and the school environment. This includes, but is not limited to; established relationships between care coordinators and school nurses, social workers and special education coordinators, attendance of care coordinators at school meetings, the UCFS Chief Medical Director serving as the Medical Director of local school districts, capturing IEP/504 Plans in member files and utilizing a Z-code to capture school-related activities during medical visits.
Cultural Competency	UCFS provides a gender-confirming culture for LGBTQ individuals as evidenced by questions in the annual demographic template and an LGBTQ program.
	"Lunch and Learn" trainings are held that focus on cultural competency topics.
Competencies in Care for Individuals with	Specialized equipment is offered to accommodate members with disabilities such as adjustable exam tables, wheelchair and wide-base scales and bariatric wheelchairs

REVIEW AREA	STRENGTH
Disabilities	and tables.
	An identified Z-code is used for documentation of disability determination.
Social Determinants of Health	UCFS contracts with an external entity to house a staff person dedicated to assessing and addressing SDoH.
	UCFS utilizes Z codes for documentation of SDoH.

OPPORTUNITIES FOR IMPROVEMENT

The table below represents the opportunities for improvement identified during the desk and onsite review process. A detailed “Recommendations for Improvement Plan” can be found in Appendix A of this report.

Please note that identification of CYSHCN and members with disabilities posed challenges for many of the PEs, and therefore, the challenges identified at this PE are not unique. DSS recognizes that definitions for these populations vary and identification of these members is new for PEs under the PCMH+ program. As such, DSS will continue to provide technical assistance to assist the PEs to meet the requirements of PCMH+ for these specialty populations.

REVIEW AREA	OPPORTUNITY
Program Operations	UCSF utilizes an electronic medical record (EMR) that is not an efficient tool; navigation is difficult and it is hard to find information due to the lack of integration from multiple data sources. UCSF plans launch Educating Practices in the Community (EPIC) as their EMR with an estimated implementation date of March 2020.
	UCSF is continuing to recruit members for their PCMH+ oversight body. Two PCMH+ members were recently recruited.
	UCSF reports a low penetration rate of less than 1%.
Physical Health- Behavioral Health Integration	UCSF is developing processes to document discussions with members around psychiatric advance directives in the member file.
	The evidence based digital application myStrength is not integrated into the EMR and it is unclear how many members utilize the tool.
	While evidence of care planning exists for Transition Age Youth, UCFS is developing processes to quantify the number of Transition Age Youth with transition care plans or whether plans have been updated or developed.
Children and Youth with Special Health Care Needs	UCFS is developing processes to track discussions with members and families around advance directives for CYSHCN.
	UCFS is developing processes to obtain and store IEPs and 504 Plans in the member files.

REVIEW AREA	OPPORTUNITY
Competencies in Care for Individuals with Disabilities	UCFS is developing processes to report on the number of members with disabilities on the monthly report.
	UCFS is developing processes to report on the number of members who received an adjusted appointment time on the monthly report.
Cultural Competency	The chart review demonstrated that some, but not all, plans of care incorporated members' cultural needs.

3
DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

PCMH+ Program Operations Requirements

PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from the Joint Commission. Additional program requirements include:

- Operate an oversight body with substantial participation by PCMH+ members
- Identify a PCMH+ senior leader and clinical director
- Employ sufficient and qualified staff to provide enhanced care coordination services
- Submit monthly reporting to DSS

PCMH+ Program Operations Findings

- UCFS has two oversight bodies; the Consumer Advisory Board and the PCMH+ Steering Committee (both of which report to the Board of Directors). Members on the Board are required to undergo a background check. Additionally, signed conflict of interest forms are required and training on topics such as risk management and governance are provided. Similar to other PEs, it has been challenging to recruit PCMH+ members to participate on the Consumer Advisory Board. Currently, two PCMH+ members serve on the board. The PE continues to recruit PCMH+ members by offering incentives for participation such as child care, transportation and dinner.
- UCFS has identified a senior leader (Cara Westcott, LCSW) and a clinical director (Ramindra Walia, MD) to provide oversight and leadership for the PCMH+ program. Both are each dedicated to the program 10% of the time.
- Enhanced care coordination member penetration rates are low for the 6,123 assigned PCMH+ membership (average of 0.7% as of January 2019), but appears to be tracking upward. Care coordinators average 8.4 care coordination contacts per month.
- UCFS submits the monthly reports on timely basis.

UNDER-SERVICE

Under-service Requirements

In order to ensure that savings within the PCMH+ program do not result from limitations on members' access to medically necessary services, or members with complex care needs are not removed from a PE's practice for reasons associated with high-cost. Requirements include:

- Develop a planned approach to monitor, identify and address under-service. The approach must be designed to monitor and identify potential underservice utilization or inappropriate reductions in access to medically necessary care that includes prohibiting these practices and educating staff.

- PEs will be disqualified from receiving shared savings if they demonstrate any or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.

Under-service Findings

- UCFS monitors potential under-service through several methods, including reviewing claims data, metrics, adverse incidents, complaint and member/family satisfaction. Because the EMR does not identify whether members are part of PCMH+, the potential for under-service is lessened. Additionally, UCFS follows standard of care guidelines and protocols, which expressly forbid under-service.

- Quality of care (QOC) incidents (along with "near misses") are tracked in a work plan and followed closely. QOC incidents and trends are also discussed in quarterly Quality Assurance meetings.

- A robust peer review system, member chart reviews and interviews with staff discussing member care are other methods to ensure QOC. Trends are identified and if any issues are found, follow up may include remedial training with a particular provider or refresher training if issues are widespread.

- The desk and onsite review conducted by Mercer did not detect under-service.

ENHANCED CARE COORDINATION

PH-BH Integration Requirements

Requirements for PH-BH integration align with the goals of the PCMH+ program. PCMH+ PH-BH requirements include:

- Use of standardized tools to expand BH screenings beyond depression.
- Promote universal BH screening across all populations, not just those traditionally identified as high risk.
- Obtain and maintain a copy of psychiatric advance directives in the member file.
- Obtain and maintain a copy of a member's Wellness Recovery Action Plan in the member file.
- FQHCs only: Employ a care coordinator with BH experience who serves as a member of the interdisciplinary team and has the responsibility for tracking members, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.
- FQHCs only: Expand development and implementation of the care plan for Transition Age Youth with BH challenges.
- FQHCs only: Develop Wellness Recovery Action Plans or other BH recovery planning tools in collaboration with the member and family.
- FQHCs only: Use of an interdisciplinary team that includes BH specialists, including the required BH Care Coordinator.

PH-BH Integration Findings

- UCFS utilizes a variety of screening tools, including the Patient Health Questionnaire-2 (PHQ-2) and PHQ-9, Pediatric Symptom Checklist-17 (PSC-17), CAGE-AID, Modified Checklist for Autism in Toddlers (MCHAT) and Ages and Stages (ASQ). The member file review showed evidence that the PHQ-2 and CAGE-AID are consistently utilized. Members complete the screening tool(s) with assistance, if needed. Results are either scanned into the member record or incorporated into the member questionnaire, which is part of the overall record.
- A positive BH screen results in further screening and possibly a referral for those identified as at-risk for depression or substance use. Members may be referred to the embedded BH clinician, the behavioral health care coordinator or to the BH on-call social worker for crisis intervention. Warm handoffs are utilized for urgent as well as non-urgent BH referrals.

- When appropriate, members with BH needs are referred to a Psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN) for a conversation concerning psychiatric advanced directives. UCFS refers members to Legal Aid to also assist in the process. However, UCFS has not been able to quantify the number of psychiatric advance directives obtained for the member files or discussions that are occurring. Additionally, the member file review did not contain evidence of any advance directives. UCFS notes they are working on a plan to implement and track discussions around psychiatric advance directives.

- UCFS recently implemented myStrength, an evidence-based digital application, as their Wellness Recovery Action Plan. Members may complete the tool themselves on their own time or with assistance from a clinician. Staff have been trained on the tool and the PE has set aggressive goals for implementation (75% of members are provided with information about the tool and 20% of members are registered with a myStrength account by the end of the first year.) UCFS has been unable to quantify how many members actually utilize the tool. Additionally, the myStrength tool is not currently connected to the EMR.

- UCFS identifies Transition Age Youth as all members aged 16 to 25, although the range could be extended to children as young as 12 years. Documentation showed that Transition Age Youth include youth who have BH, PH or other intellectual disabilities or who otherwise may require assistance transitioning into the adult care system. Care coordinators assist members and families with this transition and provide resources that address educational, vocational and independent needs along with medical transition. While there was evidence in the member files of care coordination intervention to assist the member in transitioning to adult services and assessing for needs, including Transition Age Youth with BH challenges, UCFS has not been able to quantify the number of Transition Age Youth with transition care plans or whether those plans have been updated or developed.

- UCFS has developed a Transition Age Youth care plan template that was developed with input from the PE's CYSHCN care coordinator.

- UCFS holds daily interdisciplinary care team huddle meetings in the Norwich site. Outside of Norwich, interdisciplinary meetings are held about five times a month and include the BH supervisor. A monthly integrated care team meeting is held with all BH providers, primary care providers and a prescriber. Medical directors meet monthly and weekly meetings are held with BH nursing supervisors.

Children and Youth with Special Health Care Needs Requirements

CYSHCN and their families often need services from multiple systems — health care, public health, education, mental health and social services. PCMH+ requirements include:

- Require advance care planning discussions for CYSHCN.

- Develop advance directives for CYSHCN.

- Including school-related information in the member's health assessment and health record, such as: The IEP or 504 Plan, special accommodations, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment.

Children and Youth with Special Health Care Needs Findings

- About 3.3% of UCFS' population has been identified as CYSHCN on the monthly report. UCFS employs a fulltime care coordinator dedicated to CYSHCN. Since 2007, UCFS has been designated the Eastern Region contractor for CYSHCN.

- The care coordinator takes a lead role in providing information and resources to the family and assists as needed in developing the advance directive. Although advance care planning discussions are occurring through a team approach with the family, provider(s) and care coordinator, no evidence existed within the member files of a discussion regarding advanced directives or that a copy was included in the record. UCFS is developing a process to track advance care discussions.

- UCFS fosters relationships with schools on behalf of CYSHCN and their families by attending school meetings at parents' requests, providing recommendations to school personnel and completing forms and surveys as requested, In addition, the UCFS Chief Medical Director serves as the Medical Director of local school districts. A process exists to capture school-related information for CYSHCN as well as scanned IEPs and 504 Plans, when provided by parents. UCFS is working to better track the number of 504 Plans/IEPs obtained from families.

Competencies Caring for Individuals with Disabilities Requirements

PCMH+ requirements for individuals with disabilities pertain to include:

- Expand the health assessment to include questions about: Durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.

- Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.

- Develop and require mandatory staff disability competency trainings to address the care of individuals with physical and intellectual disabilities.

- Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam tables) and communication adaptive equipment.

- Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment).

- Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).

Competencies Caring for Individuals with Disabilities Findings

- Members with disabilities initially self-identify. Providers then assess the disability and assign the Z02.71 Encounter for Disability Determination to the visit. A needs assessment is begun at intake and completed during the member's appointment. The embedded Case Manager completes the needs assessment and summarizes needs into the EMR in an extractable note format. The member file review noted the process and follow up, but it is still a challenge to capture data on the number of individuals with disabilities. A recently developed procedure will include disability screenings for new members and for those seen for annual exams, as well as use of a more comprehensive screening tool.

- The member file review indicated evidence of identification of unique needs but lacked consistent follow-up by the care coordinator. For example, one record included notes of the care coordinator following up with a wait list housing status and following up a week later regarding the housing application, however, there was no follow up since January 30, 2019.

- Procedures (including pre-visit planning) exist to adjust appointment times for members who require more time due to physical, communication or other needs, but this information has not yet been quantified or reported on the monthly report. The PE estimates adjusted appointment time data will be collected during the first quarter 2019.

- One disability workgroup ("Defining Disability and How to Identify") was among the trainings offered to UCFS staff in 2018.

- UCFS provides support and accommodations for members including allowing service animals, providing visual support aids and interpretation services, offering ADA-compliant parking, access, automatic or push-button doors, restrooms and equipment. Additionally, adjustable exam tables, wheelchair and wide-base scales, bariatric wheelchairs and tables are provided. Care coordinators provide additional information to teams educating them about members with disabilities.

Cultural Competency Requirements

PCMH+ program Cultural Competency requirements include:

- Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.
- Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.
- Compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

Cultural Competency Findings

- All clinical and non-clinical staff are required to attend a mandatory cultural competency training annually. Clinical in-services are also presented, along with “Lunch and Learns” on subjects such as disparities in health care. The UCFS Vice President of People leads the Cultural Competency Committee.
- UCFS reports efforts to hire a diverse workforce reflective of their overall member population, both culturally and linguistically. One example is offering a pay differential to multi-lingual staff (intake staff at UCFS is bilingual). UCFS serves members regardless of race, culture, age, gender, sexual identity and native language.
- The annual demographic template in the EMR prompts for cultural preferences including gender preference, sexual orientation, preferred language and race. Additional cultural preferences were discussed within progress notes such as identifying a member’s American Indian/Alaskan Native heritage and that the member finds support from their tribal community and their spirituality. However, identification of cultural needs and preferences was not consistent across all member files.
- UCFS addresses cultural and linguistic needs of members by providing translation and interpreter services (certain UCFS employees are trained as medical interpreters for limited English proficiency members), offering member materials in multiple languages, and considering CLAS standards when developing staff in-services, creating job descriptions, performing complaints/grievances and performing.

COMMUNITY LINKAGES

Community Linkages Requirements

In an effort to meaningfully impact SDoH, promote physical and behavioral health integrated care, and assist members in utilizing their Medicaid benefits, community linkage requirements include:

- Implement and enhance contractual relationships or informal partnerships with local community partners. Community Partnerships will meaningfully impact social determinants of health,

promote physical and behavioral health integrated care, and facilitate rapid access to care and needed resources.

- Sponsor local community collaborative forums or participate in existing collaborative forums to develop broader understanding and partnerships between health providers and community resource agencies.

- Demonstrate the results of engaging in partnerships, available access for members to various types of medical and non-medical services and observations regarding the potential short-term and long-term impacts on members.

Community Linkages Findings

- UCFS has developed a list of community resources that includes partnerships with organizations that provide services assisting members with employment, mental health and addiction, senior issues, transportation, housing, clothing, utility bills, language/literacy and nutrition/food.

- Other relationships include organizations dedicated to the needs of children, education organizations, peer support services and network, social service agencies, criminal justice system, local public health entities and specialists and hospitals.

- UCFS contracts with case management staff from TVCCA CONNECT to help members access programs that address SDoH. The staff also assist with preparation of new DSS applications for eligibility determination and re-determination. TVCCA staff are located onsite at the Norwich Health Center, and travel to the offices in Griswold and Plainfield offices as needed.

- SDoH screenings are performed for all members upon intake and annually thereafter. Screening results are documented in the member record and coded with an appropriate Z-code. The Z-codes are used by the nurse care manager to identify members for referral to the TVCCA case manager.

- The care coordination notes reflect individuals' needs and interventions such as assistance with resume and job search, suppling holiday baskets, coats, gloves, bus passes and housing/rent assistance. A food bank is located onsite at the PE and when necessary, members will go home with a bag of food.

- Members who have been assessed to have a SDoH are followed by the PCMH+ care manager who coordinates additional connection to the TVCCA case manager. The PCMH+ care manager serves as the tracker for high need members and ensures that issues and needs are fully resolved and communicated to the rest of care team members.

- Staff has access to community resource guides through databases, on paper copies, and through CT Infoline 211 website. This information is stored on the UCFS shared drive for access by all staff. The Community Outreach Team maintains internal databases and updates these as

new resources are identified. Resources are regularly updated in the database and shared with staff.

MEMBER FILE REVIEW PROCESS

PEs were instructed to provide 30 of the following member files:

- Five files representative of PCMH+ members who have a BH condition and have received care coordination in the review period. PEs are encouraged to select members who have Wellness Recovery Action Plans or other recovery planning tools.
- Five files representative of PCMH+ members who are a Transition Age Youth and have received care coordination in the review period.
- Five files representative of PCMH+ members who are a CYSHCN and have received care coordination in the review period.
- Five files representative of PCMH+ members who the PE identifies as having a disability and have received care coordination in the review period.
- Five files representative of members who have been linked to community resources to address SDoH in the review period.
- Two PCMH+ members who have moved to another provider. If there were zero PCMH+ members who have moved to another provider, the PE was asked to provide two additional members who are either a member with a BH condition or a member with a disability.
- Three members who have refused care coordination services. If there were zero members who have refused care coordination, the PE was asked to provide two additional files for members who have been linked to community resources to address SDoH.

PEs were instructed to include the following in each member file:

- A demographic description or demographic page which should include at a minimum: member name, member ID, date of birth, gender and preferred language.
- A diagnosis list.
- The most recent member assessment, including an assessment of SDoH.
- Most recent plan of care. If assessed cultural needs and preferences are located elsewhere in the member file, copies of this documentation may be provided in addition to the plan of care.
- Care coordination progress notes, including, but not limited to, referrals to community resource agencies that address SDoH for the specified timeframe. PE was asked not to submit physician

or practitioner progress notes unless the notes includes coordination with or acknowledgement of care coordination activities.

- Results of most recent BH screening(s).
- Advance care directive for members with BH conditions (if applicable to the member). If declined by the member, progress notes or other evidence may be provided showing the PE's efforts.
- Copy of Wellness Recovery Action Plans or other recovery tool (if applicable to the member).
- Transition Age Youth transition plan of care (if applicable to the member).
- Evidence of advance care planning discussions or care plans for CYSHCN (if applicable to the member).
- Copies of IEPs or 504 Plans (if applicable to the member). If not able to obtain, progress notes may show the PE's efforts to obtain the documents.
- Other documentation the PE believes is relevant to the review process and demonstrates compliance with PCMH+ requirements.

MEMBER FILE REVIEW FINDINGS

General Findings

- Reviewers included two Mercer representatives who reviewed a total of 30 member files.
- The files submitted for the category "refused" indicated that the members had no further needs. Members were provided with information on how to contact the care coordinator if further assistance was needed.

Behavioral Health/Physical Health Findings

- The member files included care coordination documentation along with the PH and BH provider documentation. Within the record, the BH provider documentation included a comprehensive plan of care that contained wellness goals to be addressed during the therapy sessions.
- Member files consistently included a PHQ-2 and CAGE-AID.
- Members with BH conditions were already in active treatment, and therefore, evidence of referrals to BH following a positive BH screen was not evident in the member files.
- UCFS did not provide evidence of a discussion regarding psychiatric advanced directives or that a copy was included in the record.
- UCFS is utilizing MyStrength as their recovery planning tool; however, no copies of the plans were found in the member files reviewed.

- For Transition Age Youth, the member files demonstrated evidence of care coordination to assess for transition needs and assistance with transition to adult services.

Children and Youth with Special Health Care Needs Findings

- UCFS provides a “Directions” binder to Transition Age Youth and CYSHCN. The “Directions” binder is an organizational tool developed by DPH to help families organize important paperwork for CYSHCN and Transition Age Youth (such as medical, BH and education evaluations, IEP or 504 Plans, medication lists, provider contact information, shared plans of care and emergency care plans).

- UCFS provides evidence of coordination and communication with the school for CYSHCN. In one example, the care coordinator attended a school meeting with the member and member’s father. One of the CYSHCN files also contained a copy of the 504 Plan.

- UCFS did not provide evidence of a discussion regarding advance care planning advanced directives or that a copy of an advance directive was included in the record.

Competencies in Care for Members with Disabilities Findings

- For members with disabilities, the file review indicated evidence of identification of unique needs but lacked consistent follow-up by the care coordinator. For example, one record included notes of the care coordinator following up with a wait list housing status and following up a week later regarding the housing application, however, there was no follow up since January 30, 2019.

Cultural Competency Findings

- The annual demographic form is a template that prompts the gathering of cultural needs and preferences including gender preference, sexual orientation, preferred language and race. SDoH information is also included, such as living environment/homelessness.

- Some member files showed evidence of assessing for and documenting cultural needs and preferences in notes and plans of care. An example of capturing cultural preferences was the identification of a member’s American Indian/Alaskan Native heritage and a note mentioning the member finds support from her tribal community and her spirituality. However, this was not consistent across all member files.

Community Linkages Findings

- The UCFS member files demonstrated strong evidence of connections to community resources. The identification of specific needs was individualized and the interventions occurred rapidly.

- The care coordination notes reflect an assessment of SDoH and other complicating factors that may impact the member’s ability to comply with treatment.

- The care coordination notes also reflect an individualized approach with members and interventions, including assistance with resume and job search, suppling holiday baskets, coats, gloves, bus passes, and housing/rent.

MEMBER INTERVIEWS

Member Interview Process

The input of members is key to the success of the PCMH+ program. Interviews with current PCMH+ members and/or designated family representatives focused on the member experience with PCMH+. In particular, interview questions solicited information about the member's experience with PCMH+ care coordination services and overall satisfaction regarding delivery of these services.

The PE selected the assigned PCMH+ member (and/or their representative) to voluntarily participate in an interview designed and requested that priority be given to members who participate on the PCMH+ oversight committee or to members with at least one PCMH+ care coordination contact in the review period. Face-to-face interviews with members were preferred with the understanding that the interview team would accommodate members' schedules during the onsite review and conduct phone interviews if necessary.

Member Interview Findings

UCFS arranged three interviews with PCMH+ assigned members, all were face-to-face interviews.

- All three members were receiving PCMH+ enhanced care coordination interventions, which was confirmed by UCFS.

- The advisory board is scheduled to hold its first meeting on March 25, 2019, and two of the members interviewed will sit on the board. Both members were very excited to be able to share their opinions and feel that their voices will be heard and valued in this forum.

- None of the interviewed members had issues accessing medical care. All three agreed that their providers show an interest in their care. Each of the members felt very comfortable voicing their opinions and/or disagreeing with their provider if needed. One member stated that there is a form located at the front desk to report any issues or that you could always just tell your care coordinator about them.

- The members knew who their care coordinators were and were able to easily connect by phone or visit in person with them when needed. All three members emphasized that they noticed a difference in their care experience due to the care coordinators interventions. The care coordinators educated all three members about available services such as assistance with housing, transportation, food banks, etc. One member had been given assistance with finding a job, another member had been given assistance with transportation, while another member had been given assistance with housing and purchasing a car.

- One member expressed her gratitude for finally having a wonderful Christmas. She gave all of the credit to her care coordinator, who was able to connect her children with an organization that would provide gifts for the holidays. This member also stated that she realized that swimming is a great exercise for her in her condition so she asked her care coordinator about it and her care coordinator is working on finding a facility to make this happen. This member stated that she felt UFCS was her “Super Walmart for medical needs. Her one stop shop.”
- Another member stated that after her house burned down and the first people that showed up were from UCFS. They helped coordinate a place to stay, clothes, food, etc. for this member. She stated, “When I had nothing, UCFS was there for me!”

APPENDIX A

UNITED COMMUNITY AND FAMILY SERVICES RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	UCSF utilizes an EMR that is not an efficient tool. Navigation is difficult and it is hard to find information due to the lack of integration from multiple data sources. UCSF plans launch Epic® as their EMR with an estimated implementation date of March 2020.	While the implementation of Epic® in the future should help to alleviate current issues regarding navigation and integration of data sources, extra efforts should be made in the interim to ensure member information can be accessed by all members of the clinical team to improve coordination and delivery of care.
	UCSF is continuing to recruit members for their PCMH+ oversight body. Two PCMH+ members were recently recruited.	Formalize procedures to ensure substantial representation of PCMH+ member attendance at Member Advisory Board meetings and meet the requirement to hold meetings on a quarterly basis at a minimum.
	UCSF has a low penetration rate of less than 1%.	Evaluate PCMH+ enhanced care coordination member penetration rates and formalize procedures and documentation standards to track and increase the number of PCMH+ members engaged in care coordination activities.
Physical Health-Behavioral Health Integration	UCSF is developing processes to document discussions with members around psychiatric advance directives in the member file.	Formalize procedures to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record. Also formalize procedures to document discussions regarding psychiatric advance directives.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	The evidence based digital application myStrength is not integrated into the EMR and it is unclear how many members utilize the tool.	Formalize procedures to collect and store myStrength data in member files and procedures to accurately capture information on myStrength usage for reporting purposes.
	While evidence of care planning exists for Transition Age Youth, UCFS is developing processes to quantify the number of Transition Age Youth with transition care plans or whether plans have been updated or developed.	Formalize procedures to report on the number of Transition Age Youth with transition plans and the number updated or developed for the monthly report.
Children and Youth with Special Health Care Needs	UCFS is developing processes to track discussions with members and families around advance directives for CYSHCN.	Formalize procedures to capture the number of advance directives or discussions with members and families regarding advance directives.
	UCFS is developing processes to obtain and store IEPs and 504 Plans in the member files.	Formalize procedures to report counts of members with IEPs and 504 Plans on monthly reports.
Competencies in Care for Members with Disabilities	UCFS is developing processes to report on the number of members with disabilities on the monthly report.	Formalize procedures to report on the number of f members with disabilities on the monthly report.
	UCFS is developing processes to report on the number of members who received an adjusted appointment time on the monthly report.	Formalize procedures to report on the number of members who received an adjusted appointment times on the monthly report.
	There was inconsistent evidence that care coordinators follow-up on unique needs of members with disabilities.	Formalize procedures to ensure care coordinators follow up and document the unique needs of members with disabilities.
Cultural Competency	The chart review demonstrated that some, but not all, member records and plans of care incorporated members' cultural needs.	Formalize procedures to incorporate cultural needs and preferences more consistently within members' plans of care.

MERCER (US) INC.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com