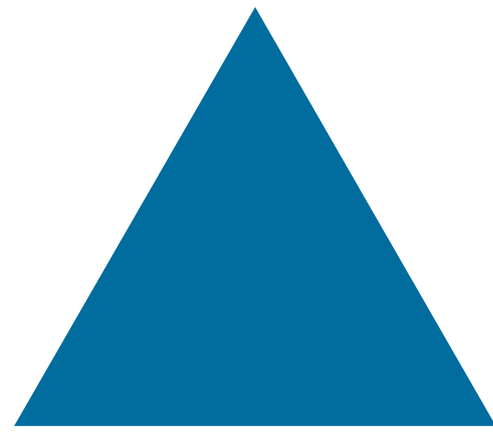
HEALTH WEALTH CAREER



2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF CHARTER OAK HEALTH CENTER

AUGUST 31, 2017

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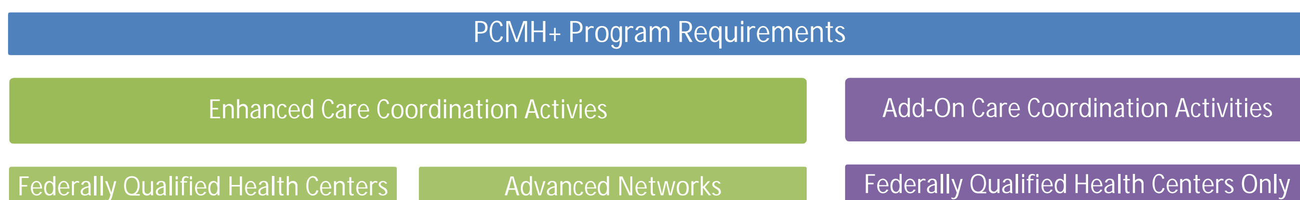
1 INTRODUCTION

The Person-Centered Medical Home Plus (PCMH+) program is part of the Connecticut Department of Social Services' (DSS) investment in value-based purchasing and care coordination to reduce Medicaid expenditures while improving service quality and member health outcomes. PCMH+ builds on the DSS PCMH program started by DSS January 1, 2012 currently serves 61% of HUSKY Medicaid members and has successfully supported the practice transformation of 112 practices (as of September 2017) to achieve PCMH recognition. PCMH+ is a Shared Savings model where a participating entity (PE) that meets specific quality improvement targets and saves money for the program, may share in a portion of HUSKY program savings. The PE's quality measure scoring and PCMH+ program savings calculations, for Wave 1 (PCMH+ Program Year 1) will be conducted Fall 2018 and are not evaluated as part of this PCMH+ Compliance Review. This review is focused on evaluating PCMH+ PE compliance with PCMH+ program requirements, identifying best practices and opportunities for improvement.

DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite for eligibility for the PCMH+ program.

PCMH+ PROGRAM REQUIREMENTS

PCMH+ expands care coordination provided to members through required Enhanced Care Coordination interventions and actively promotes physical and behavioral health integrated service delivery. The PCMH+ program requirements include enhanced care coordination activities and operational standards that all PEs must meet.



For PEs, like Charter Oak Health Center (COHC) that are a federally qualified health center, there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice, including a qualified BH enhanced care coordinator (ECC) on staff who is an active participant in the COHC's interdisciplinary team(s) and development of Wellness Recovery Action Plans for members with BH conditions. The following table provides a summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are in Section 3.

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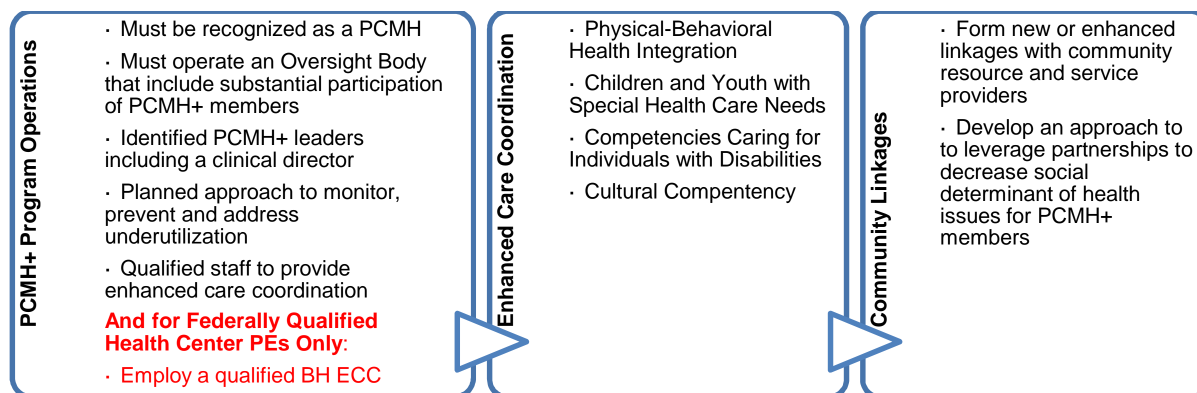
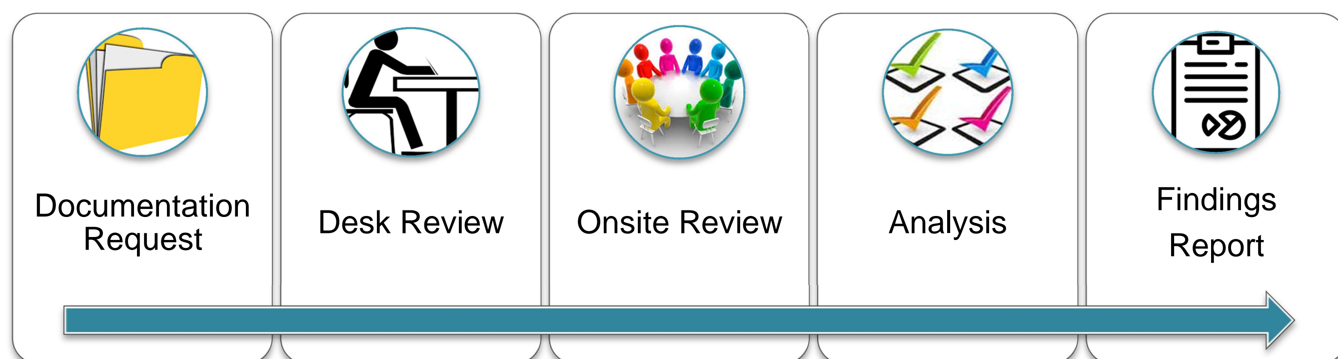


REVIEW METHODOLOGY

The PCMH+ Wave 1 program review focused on evaluating operations and service delivery, including compliance with program standards, quality and effectiveness in achieving the goals of the DSS PCMH+ program. The review evaluated the implementation and operations of the PE's PCMH+ program since the go-live date of January 1, 2017 through August 2017 and was organized into five phases presented in the following diagram:



DOCUMENT REQUEST — JUNE 2017

Mercer developed a comprehensive PCMH+ Document Request that was shared with the PE in an effort to gather information regarding the PE's PCMH+ program. The request solicited a variety of documents, such as organizational charts, PCMH+ staffing, member participation in oversight, policies and procedures regarding care coordination, community linkages and assistance of members with special healthcare needs and disabilities, related to the PCMH+ program requirements. In addition, the Documentation Request solicited brief narrative responses to questions related to the implementation of the PCMH+ program in an effort to understand the PE's operations and approach to implementing the PCMH+ program within their practice(s).

DESK REVIEW — JULY 2017

Mercer received information electronically and reviewed all documents submitted to evaluate the PE's compliance with PCMH+ program requirements as detailed within the PCMH+ Request for Information. Areas where Mercer could not determine that the process or procedure was fully

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compliant with PCMH+ program standards were noted for follow-up discussion during the onsite interviews.

ONSITE REVIEW — AUGUST 2017

The onsite review for COHC took place on August 31, 2017, at the offices located in Hartford, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff and appropriate COHC leadership. After the introductory session, the track teams split out into concurrent sessions and concentrated on the following areas focused specifically on PCMH+ program operations and PCMH+ assigned members; Program Operations, Enhanced Care Coordination, Member File Reviews, Member Interviews and Community Linkages. Onsite interviews included the following COHC staff:

- Kristen Harris — Chief of Compliance and Legal Affairs
- Stew Joslin — CFO
- Rashad A. Collins — COO
- Ann Patterson — Chief Quality Assurance Officer
- Staci Beamon — Interim Director of Nursing
- Kellie Ford — Advance Practice Registered Nurse (APRN)
- Timothy Conde — ECC/Community Health Worker
- Zuleika Cruz — ECC/ Community Health Worker
- Isreal Reyes — ECC/ Community Health Worker

ANALYSIS AND FINDINGS REPORT — SEPTEMBER 2017

Information from all phases of the assessment process was gathered and a comprehensive analysis was completed. Results of this analysis make up this report.

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SUMMARY OF FINDINGS

COHC PCMH+ PROGRAM OVERVIEW

COHC is a federally qualified health center that provides an array of primary care and specialist care to its members including BH, cardiology, dental, nutrition, lab and radiology, optometry, pain management, pediatrics, pharmacy, podiatry, urology, and women's health throughout Hartford, Connecticut. COHC operates at two sites in Hartford and offers extended hours (until 6 pm during the week and Saturday and Sunday hours). Additional services include a mobile dental clinic, two school-based health centers, medical services at seven homeless shelters, community outreach and entitlement enrollment services. Additionally, COHC reports that they recently received substance use disorder certification within the last year and a grant to address opioid use and will be partnering with Community Health Resources, a sister organization, which has deep substance use disorder experience.

Under PCMH+, COHC provides enhanced care coordination activities to 6,870 PCMH+ members. Staffing for PCMH+ includes four ECCs/Community Health Workers, one of whom is the BH ECC/ Community Health Worker, who are 100% dedicated to the PCMH+ program. These ECCs directly interface with PCMH+ members to help develop individualized care plans and establish relationships to assist members on their journey to wellness. The ECCs report to the PCMH+ Program Lead RN, who supervises and directs the workflow of the ECCs as well as develops care plans, creates member engagement/assessment tools and develops forms, systems and processes. The PCMH+ Program Lead RN reports to the PCMH+ Clinical Director and APRN, who serves as a liaison to the primary care clinicians. Weekly meetings are held between the PCMH+ Program Lead RN and the PCMH+ Clinical Director to review and discuss PCMH+ program issues. COHC reports the following monthly care coordination contacts: April 2017: 751 contacts; May 2017: 668 contacts; June 2017: 546 contacts; July 2017: 646 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	COHC has equipped their ECCs with laptops with connectivity and cell phones with text capability to facilitate optimal on and off-site communication with their team members.
	COHC requests that members engaged in care coordination supports sign a pledge agreeing to partner with the ECC in his or her health care. This has promoted high levels of engagement from the members in working toward health and social determinants of health goals.
	COHC has provided their PCMH+ members with pedometers, digital scales, blood pressure devices and meal portion kits to help promote a healthier lifestyle.

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REVIEW AREA	STRENGTH
Program Operations	COHC has 6,870 PCMH+ members assigned. Based on their PCMH+ Monthly Provider Reports submitted to DSS, there have been 751 care coordination contacts in April 2017, 668 care coordination contacts May 2017, 546 care coordination contacts in June 2017 and 646 care coordination contacts in July 2017.
Physical Health-Behavioral Health Integration	COHC has significantly expanded BH staff by hiring one clinician per month over the last six months. COHC currently employs eight clinicians, 1.2 FTE psychiatrists and a psychiatric APRN. COHC has also expanded BH groups for members over the last three months by adding groups such a men's depression group, therapeutic meditation, pain management and a women's only group.
Cultural Competency	COHC demonstrates a strong commitment to hiring a diverse workforce that meets the diversity of the members served. All four ECCs are multicultural and three are bilingual.
	COHC identified a need for easier and after-hours access to language interpretation for members and now uses CyraCom® which provides language interpretation services via a tablet.
	COHC collects a robust set of cultural elements as part of the member intake such as race and ethnicity, language preferences, sexual orientation, sexual identity and gender identity.
Community Linkages	The ECCs utilize a structured, in-person initial assessment with each member that can occur either in the federally qualified health center or in the member's place of residence. The assessment includes a review of social determinants of health such as housing, psychosocial support, legal needs, transportation needs, social support and family issues and cultural factors. The assessment leads to linkages to community resources and the development of an individualized care plan.
	COHC has established a strong collaborative relationship with Connecticut 2-1-1. Representatives from 2-1-1 are onsite on a weekly basis to assist members directly with linkages to community resources.
Member File Reviews	COHC has a comprehensive assessment that clearly identifies social determinants of health and unique needs of the member. From the comprehensive assessment, COHC creates plans of care for specific conditions and outlines interventions for the members which include nutrition and prescription education, and organized member activities.
	COHC coordinates member's transportation, appointments, assists with paperwork and offers resources for members.
	COHC uses member materials translated into the members identified language, Spanish forms and assessments were found in the file review.
	Multiple files reviewed showed members were actively engaged in the PCMH+ advisory committee.

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OPPORTUNITIES

Note the Recommendations for Improvement Plan is found in Appendix A of this report.

AREA	OPPORTUNITY
Physical Health-Behavioral Health Integration	COHC is still developing their process to develop Wellness Recovery Action Plans with members, but currently asks members if they have a Wellness Recovery Action Plan and incorporates that information into the member's plan of care.
Children and Youth with Special Healthcare Needs	COHC is still developing processes to identify Children and Youth with Special Health Care Needs. COHC has developed an addendum to the intake form specifically for children.
Competencies in Care for Individuals with Disabilities	COHC is in the process of assessing the need for adaptive equipment in their service sites for members with disabilities.
Member File Reviews	There is an opportunity to identify transition age youth and Children and Youth with Special Health Care Needs that could benefit from enhanced care coordination. Files representing these types of members demonstrated no outreach for care coordination at the time of the file review. Identification of these types of members will offer opportunity to evaluate their care coordination and/or resource needs.

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DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

A. PCMH+ Program Operations Requirements

As the PCMH+ program builds upon PCMH practice requirements, all PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee of Quality Assurance or Primary Care Medical Home certification from The Joint Commission. Additional operational requirements include:

- Having an oversight body, supporting PCMH+ which includes substantial representation by PCMH+ Members.
- Having a senior leader and a clinical director providing oversight for the PCMH+ program
- Having sufficient care coordination staff to provide the enhanced care coordination required activities to provide timely care coordination to PCMH+ assigned members.
- Having a quality program, including annual goals and annual quality work plan that includes specific PCMH+ program goals and activities.
- Evaluating and utilizing the results of provider profile reports to improve the quality of care.
- Completing and submitting the PCMH+ monthly report based on specifications provided by DSS.

B. PCMH+ Program Operations Findings

- Provider profile reports and Care Analyzer information provided by the HUSKY Administrative Services Organization-CHNCT are used to identify gaps in care and take immediate action to address those gaps. Each week the PCMH+ Program Lead RN reviews and distributes the reports to the ECCs. The ECCs call the members listed and perform follow up, schedule appointments and/or provide education.
- COHC conducted initial screening of all attributed PCMH+ members to determine the highest risk members and those who would benefit most from enhanced care coordination. Initial focus in on members diagnosed with four or more of chronic conditions: hypertension, diabetes, asthma, depression and obesity.
- COHC has equipped their ECCs with laptops with connectivity and cell phones with text capability to facilitate optimal on and off-site communication with their team members.
- COHC requests that members engaged in care coordination supports sign a pledge agreeing to partner with the ECC in his or her health care. This has promoted high levels of engagement from the members in working toward health and social determinants of health goals.
- COHC has provided their PCMH+ members with pedometers, digital scales, blood pressure devices, and meal portion kits to help promote a healthier lifestyle.
- ECCs conduct outreach to members by making home visits when providers cannot reach a PCMH+ member. During the home visits, the ECC will go over important lab results or other

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follow-up care, inform the member if they need to call their provider, discuss the PCMH+ program, and/or schedule appointments.

- COHC has created a PCMH+ Patient Advisory Committee to support the goals and policies of their PMCH+ program. To solicit member participation, COHC contacted active members, posted flyers, offered food, refreshments and bus tokens to members that wanted to attend. There have been three PCMH+ Patient Advisory Committee meetings held with seven PCMH+ members attending in April 2017, 16 PCMH+ members attending in June 2017 and one PCMH+ member attending in July 2017. At each meeting the PCMH+ Lead RN solicits feedback from members and reports this information back to the PCMH+ team during the weekly PCMH+ Administrative meeting.
- COHC has a robust quality program which includes annual goals, description of the oversight of the quality management program, committee structure, quality improvement policies and procedures, quality assessment and metrics, and a performance improvement tool kit.
- COHC conducted agency wide training for staff and providers on the elements of PCMH+ to increase familiarity and to share program objectives.
- COHC has 6,870 PCMH+ members assigned. Based on their PCMH+ Monthly Provider Reports submitted to DSS, there have been 751 care coordination contacts in April 2017, 668 care coordination contacts May 2017, 546 care coordination contacts in June 2017 and 646 care coordination contacts in July 2017.

UNDERSERVICE

A. Underservice Requirements

In order to ensure that savings within the PCMH+ program are not derived by practices that limit a member's access to medically necessary services, or that complex members with higher cost needs are not shifted out of a PE's practice. Requirements include:

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

B. Underservice Findings

- There was no evidence of underservice noted during the review.
- PCMH+ Executive Team Leads review center-wide member complaints to determine if there are any member complaints indicating an effort from staff to discourage members from accessing services.
- COHC uses their "Code of Conduct" training to educate staff that underservice or panel manipulation is prohibited. In the event that underservice or panel manipulation is suspected or identified, the Chief of Compliance & Legal Affairs, one of the PCMH+ Program's Executive Team Leads, will immediately launch an investigation and take any corrective action deemed necessary to prevent a recurrence.

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ENHANCED CARE COORDINATION

A. Physical Health-Behavioral Health (PH-BH) Integration Requirements

Increased requirements for PH-BH integration align with the goals of the PCMH+ program and follow national trends in healthcare. PCMH+ PH-BH requirements include:

- Using standardized tools to expand BH screenings beyond depression; promotion of universal screening for BH conditions across all populations, not just those traditionally identified as high risk;
- Obtaining and maintaining a copy of a member's psychiatric advance directive in the member's file; and
- Obtaining and maintaining a copy of a member's Wellness Recovery Action Plan in the member's file.
- Expanding development and implementation of the care plan for transition age youth with BH challenges.
- For federally qualified health centers only: Develop Wellness Recovery Action Plans in collaboration with the member and family.

B. PH-BH Integration Findings

- COHC screens all members universally for BH conditions with the PHQ-2/9. Currently, the PHQ-2 is completed by the BH clinicians; however, COHC is considering transitioning this task to the ECCs.
- COHC screens members for BH conditions beyond depression. Screenings include the SAD Persons Scale and the Generalized Anxiety Disorder 7-item scale. COHC intends to expand screening to include SBIRT (Screening, Brief Intervention, and Referral to Treatment is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs) in the future.
- For members screening positive for a BH condition, a warm handoff occurs. The ECC schedules a BH appointment and the ECC actively engages in follow-up with the member to ensure attendance at the appointment.
- COHC has significantly expanded BH staff by hiring one clinician per month over the last six months. COHC currently employs 8 clinicians, 1.2 FTE psychiatrists and a psychiatric APRN. COHC has also expanded BH groups for members over the last three months by adding groups such a men's depression group, therapeutic meditation, pain management and a women's only group.
- COHC has formalized procedures to assess the presence of a psychiatric advance directive using the member intake form and every three months following intake. The policy and procedure indicates that a psychiatric advance directive is considered a part of a complete medical record. If a member has a psychiatric advance directive, a copy is requested and scanned into the electronic health record. Members who request a psychiatric advance directive are provided information by the BH clinicians. COHC is still developing their Wellness Recovery Action Plan processes, but currently asks members if they have a Wellness Recovery Action Plan and incorporates that information into the member's plan of

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care. COHC intends to develop Wellness Recovery Action Plan through a group planning process led by a BH clinician.

- COHC currently defines transition age youth by the age band of 16-24 years. Currently, COHC identifies 1085 members as transition age youth and is planning to refine the definition used to more strategically identify transition age youth based on needs for care coordination.
- COHC holds weekly multidisciplinary team meetings. The BH ECC and ECCs participate in the meetings and the BH ECC is invited to present on members with challenging needs. Case presentations at the multidisciplinary team meetings are documented and required actions are incorporated into the member's care plans if appropriate. The multidisciplinary team meetings often result in an increase in care coordination from the BH ECC and ECCs for the members presented.

A. Children and Youth with Special Health Care Needs Requirements

Children and Youth with Special Health Care Needs and their families often need services from multiple systems – health care, public health, education, mental health and social services. PCMH+ Children and Youth with Special Health Care Needs requirements include:

- Holding advance care planning discussions for Children and Youth with Special Health Care Needs.
- Developing advance directives for Children and Youth with Special Health Care Needs.
- 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.

B. Children and Youth with Special Health Care Needs Findings

- COHC is still developing processes to identify Children and Youth with Special Health Care Needs. COHC has developed an addendum to assess for special health care needs within their intake form.
- COHC is working to establish relationships with local schools and has begun to collect IEPs and 504 plans.

A. Competencies Caring for Individuals with Disabilities Requirements

PCMH+ requirements for individuals with disabilities pertain to members with physical, intellectual, developmental and BH needs, and includes:

- Expanding the health assessment to evaluate members with disabilities for needed special accommodations in order to remain at home or access medical care or community resources.
- Adjusting appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs.
- Developing and requiring mandatory staff disability competency trainings to address the care of individuals with physical and intellectual disabilities.

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

B. Competencies Caring for Individuals with Disabilities Findings

- COHC has a formalized process to assess members for disabilities and associated accommodations and documents these from the member intake form. Once noted, the PCMH+ Lead works directly with individuals to further assess their needs and ensure accommodations are recorded in the member file. Accommodations can include needs such as adjusted appointment times and barriers to communication.
- COHC is assessing the need within their facilities for adaptive equipment for members with disabilities.

A. Cultural Competency Requirements

Incorporating a member's cultural preferences and acknowledging that culture can expand beyond language and ethnicity is a key tenet of the PCMH+ program. Cultural sensitivity can help inform care coordination and other service interventions to better assist the member, particularly with regard to social determinant of health and community resource needs. The following are PCMH+ program Cultural Competency requirements:

- Conducting annual cultural competency training that includes methods to address the needs of members with disabilities for all practice staff.
- Expanding the individual care plan to include an assessment of the impact culture has on health outcomes.
- Integrating culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

B. Cultural Competency Findings

- COHC provides annual cultural competency training for all staff. New staff also complete cultural competency training as part of the new hire process.
- COHC demonstrates a strong commitment to hiring a diverse workforce that aligns with the diversity of the members served. All four ECCs are multicultural and three are bilingual. Many of the medical assistants and member center representatives are multicultural and bilingual. Many members speak either Spanish or Bosnian as their language of preference.
- COHC has established standards for language interpretation services and requires that in-house interpreters to be American Health Education Center certified and complete the American Health Education Center medical interpretation training. COHC also developed a new language access plan which established clear policies regarding who may provide translation services.
- COHC identified a need for easier and after-hours access to language interpretation for members and now uses CyraCom® which provides language interpretation services via a tablet.
- COHC demonstrates a commitment to increasing the cultural competence of the organization and has collaborated with the Hispanic Health Council, a local organization, to provide a four-hour training on unconscious bias for the entire staff.

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- COHC has a process in place to address member complaints that are culturally-based and will counsel the provider or staff member and deliver additional training to the staff person in order to prevent further complaints of this nature.
- COHC collects a robust set of cultural elements as part of the member intake such as race and ethnicity, language preferences, sexual orientation, sexual identity and gender identity.
- COHC recently developed a member non-discrimination policy which ensures that members may not be discriminated against across many domains, including disability.

COMMUNITY LINKAGES

A. Community Linkages Requirements

In an effort to meaningfully impact PCMH+ members' social determinants of health, PEs are required to develop contractual or informal partnerships with local community partners, including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, and elder support services, and to further develop processes to link members to resources and community supports.

B. Community Linkages Findings

- COHC has established a strong collaborative relationship with Connecticut 2-1-1. Representatives from 2-1-1 are onsite on a weekly basis to assist members directly with linkages to community resources and brochures are distributed to members. The ECCs have received training on 2-1-1 in order to enhance their knowledge of the full range of services available to members.
- COHC has established relationships with local organizations that provide services in the immediate locale and also onsite at the federally qualified health center. Local organizations include homeless shelters, Billings Forge Farmer's Market and a mobile market. COHC also offers Supplemental Nutrition Assistance Program and hosts a variety of wellness providers (yoga and meditation) onsite.
- The ECCs utilize a structured, in-person initial assessment with each member that can occur either in the federally qualified health center or in the member's place of residence. The assessment includes a review of social determinants of health such as housing, psychosocial support, legal needs, transportation needs, social support and family issues and cultural factors. The assessment leads to linkages to community resources and the development of an individualized care plan.
- The ECCs collaborate with COHC's case managers who may also assess members for social determinants of health and provide one-on-one assistance to the member to aid them in finding adequate resources to address their needs.
- COHC maintains community linkage resource lists in addition to the use of 2-1-1. The case managers maintain these lists and refresh them on an annual basis to ensure information is accurate.

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MEMBER FILE REVIEWS

A. Member File Review Process

PEs were instructed to provide 30 member files for the onsite review, from which the team would select 20 for review. A variety of files were solicited including those of:

- Five PCMH+ members who received at least two care coordination contacts since January 1, 2017.
- Five PCMH+ members who have a BH condition.
- Three PCMH+ members who are transition age youth or Children and Youth with Special Health Care Needs.
- 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 transition age youth or Children and Youth with Special Health Care Needs.
- Three PCMH+ members who are disabled.
- Two members who have transitioned from CHNCT Intensive Care Management Program.
- Five PCMH+ members who have not received a care coordination contact since January 1, 2017.
- Two members who have refused care coordination supports. 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 social determinants of health.
- Three members who were linked to community resources to address social determinants of health.

To accommodate multiple reviewers, the Mercer and DSS teams requested that member clinical records be printed for onsite review. If printed clinical records were not an option due to challenges with the electronic medical record, the PE was asked to provide files electronically during the onsite session.

We asked that files include:

- Member demographics.
- All member assessments, screenings and clinical referrals.
- Member diagnosis, problem lists and medications.
- Care coordination notes, contacts, referrals or other supports provided.
- All clinical and care coordination notes and contacts from January 1, 2017–June 30, 2017.
- Member plan of care.
- Member’s IEP (if applicable).
- Wellness Recovery Action Plan or other recovery planning documents (if applicable).
- Member’s advance care directives (if applicable).
- Other notes and documentation that support clinical and social support of member from January 1, 2017–June 30, 2017.
- Other documentation that is related to the PCMH+ program or care coordination supports.

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Reviewers included two Mercer representatives who reviewed a total of 20 member files.

B. Member File Review Findings

- COHC has a comprehensive assessment that clearly identifies social determinants of health and unique needs of the member. Questions include issues surrounding communication, substance use, legal, housing, financial, appointment adherence, psychosocial support, transportation and cultural issues.
- COHC creates individual plans of care for specific conditions, such as for depression, hypertension, asthma and obesity. Plans of care outline interventions for the members which include nutrition and prescription education, and organized member activities such as health walks, meditation groups and cooking classes.
- There was evidence of assisting members with transportation and appointments, paperwork and accessing resources.
- COHC uses member materials in the member's identified language; Spanish forms and assessments were found in the file review.
- Multiple files reviewed documented members who are actively engaged in the PCMH+ advisory committee.
- There is an opportunity to identify transition age youth and Children and Youth with Special Health Care Needs that could benefit from enhanced care coordination. Files representing these types of members demonstrated limited or absent outreach for care coordination. Identification of these types of members will offer opportunity to evaluate their care coordination and/or resource needs.

MEMBER INTERVIEWS

A. Member Interview Process

Healthy, satisfied members are key to the success of the PCMH+ program. The compliance review therefore obtained input from current PCMH+ members and/or their families/designated representatives, focusing on the member's experience with the PCMH+ program; in particular, their experience with PCMH+ care coordination, and their satisfaction with identification of unmet service, social or resource needs.

The PE invited members (and/or their representative) who were assigned specifically to the PE's PCMH+ program to voluntarily participate in an interview designed to solicit their experience with PCMH+ and their ECC if they had received PCMH+ care coordination. Mercer 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. 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.

B. Member Interview Findings

COHC arranged three interviews with four PCMH+ assigned members, all in person. One interview was attended by a married couple.

- All members were receiving PCMH+ enhanced care coordination interventions and reported being easily able to connect by phone with their ECC when needed. One mentioned that the

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ECC calls or texts when an appointment is coming up. Another mentioned the ECC will call to assess the member's current needs. The member said he can ask the ECC about non-medical needs, about the various programs and benefits COHC offers, such as classes, and the ECC assists in obtaining bus passes for members.

- All of the members attended the PCMH+ Patient Advisory Committee twice. Coffee and breakfast provided by COHC were appreciated. Two of the members felt free to bring up parking issues and a nearby sidewalk in need of repair. Another member let the board know he did not like auto-call reminders for appointments.
- Members each described a different process for making complaints, but each was confident their complaints would be heard. One member complained to his ECC about his doctor's attitude, and after the ECC talked with the provider, the provider's attitude improved to the member's liking.
- The members did not report issues accessing medical care. As one member said, "Every doctor I go to is always nice. Even the foot doctor." One member said providers at COHC were better than his prior providers in Florida. One of the members said he had "lots of appointments in all different areas" including a heart specialist at the main office.
- One member does not utilize community services since he is employed and does not have the need, but he attends several of COHC's classes. Another also does not use community services but also likes the classes. The married couple utilizes Connecticut 211 and is in process to file for disability with the aid of their ECC.
- The members enthusiastically talked about the classes offered by COHC. Together they attended Zumba®, cooking, nutrition, painting, meditation, and walking groups. The members mentioned that COHC provided them with a Fitbit®, digital scale, blood pressure device and meal portion kit. The members would like the classes to continue and one suggested a horticulture class.

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APPENDIX A

CHARTER OAK HEALTH CENTER RECOMMENDATIONS FOR IMPROVEMENT PLAN

AREA	OPPORTUNITY	RECOMMENDATION
Physical Health-Behavioral Health Integration	COHC is still developing their Wellness Recovery Action Plan processes, but currently asks members if they have a Wellness Recovery Action Plan and incorporates that information into the member's plan of care.	Formalize procedures to develop Wellness Recovery Action Plans with members.
Children and Youth with Special Health Care Needs	COHC is still developing processes to identify Children and Youth with Special Health Care Needs. COHC has developed an addendum to the intake form specifically for children.	Develop a process to identify Children and Youth with Special Health Care Needs that allows staff to accurately identify this population for outreach and support assessment.
Competencies in Care for Individuals with Disabilities	COHC is in the process of assessing the need for adaptive equipment in their service sites for members with disabilities.	Complete the assessment and include adaptive equipment for members as needed.
Member File Reviews	There is an opportunity to identify transition age youth and Children and Youth with Special Health Care Needs that could benefit from enhanced care coordination. Files representing these types of members demonstrated no outreach for care coordination at the time of the file review. Identification of these types of members will offer opportunity to evaluate their care coordination and/or resource needs.	Create a process to identify transition age youth and Children and Youth with Special Health Care Needs that could benefit from enhanced care coordination. Consider evaluation of need for individual and family resources.

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