HEALTH WEALTH CAREER

2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF COMMUNITY HEALTH CENTER

AUGUST 10, 2017

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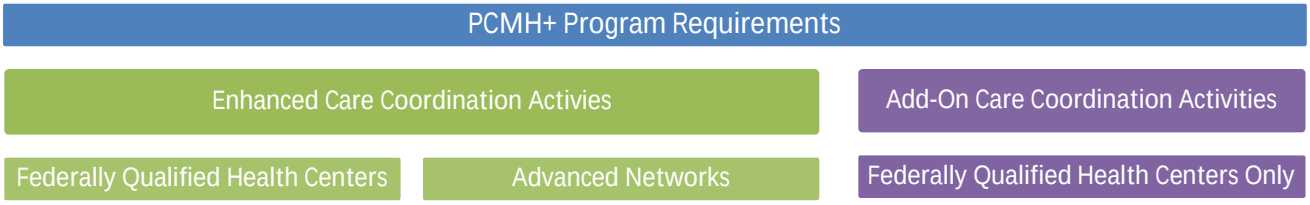
INTRODUCTION

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.

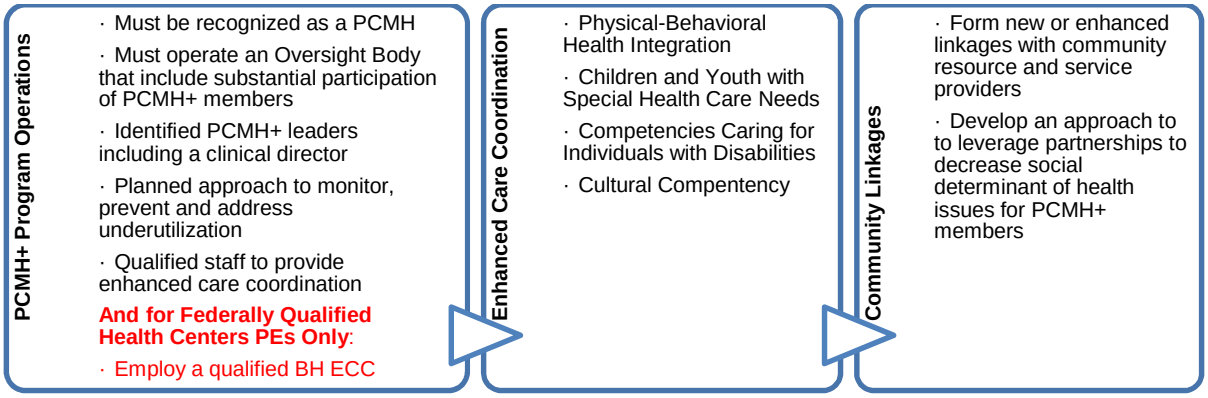
DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite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

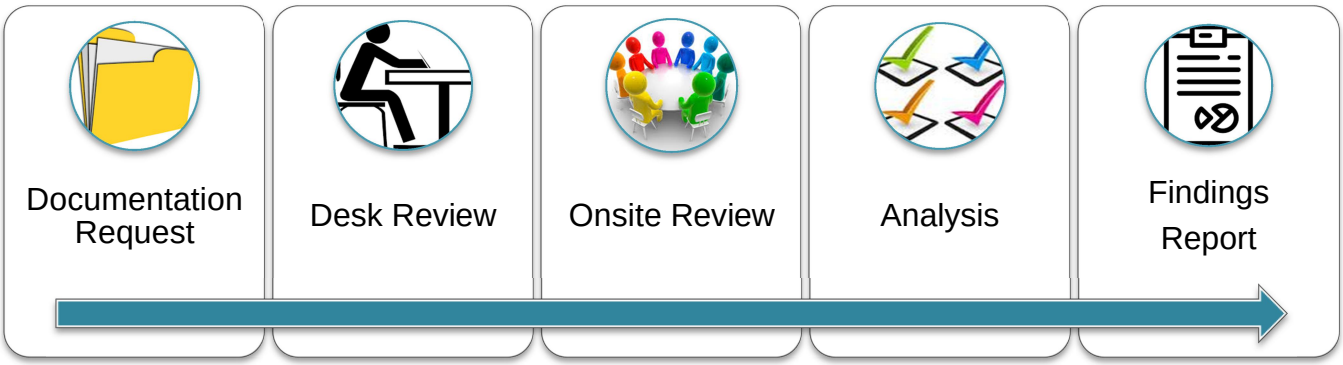


For PEs, like Community Health Center (CHC) that are a federally qualified health center, there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice, including a qualified BH enhanced care coordinator (ECC) on staff who is an active participant in CHC'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.



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

ONSITE REVIEW — AUGUST 2017

The onsite review for CHC took place on August 10, 2017, at the offices located in Middletown, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff and appropriate CHC 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 a variety of CHC staff including the following leadership and PCMH+ ECCs:

- Mark Masselli — President and CEO
- Margaret Flinter — Clinical Leader and Senior VP
- Doreen Bentson — COO
- Daren Anderson — Chief Quality Officer
- Veena Channamsetty MD — Chief Medical Officer
- Mary Blankson — Chief Nursing Officer
- Tim Kearney — Chief BH Officer
- Yvette Highsmith Francies — Regional VP
- Amy Taylor — Regional VP
- Melissa Mato — ECC
- J.D. Ospina — ECC
- Angela Camacho — BH ECC

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

CHC PCMH+ PROGRAM OVERVIEW

CHC is a federally qualified health center that provides comprehensive primary care services in medicine, dentistry and BH as well as onsite psychiatry, podiatry and chiropractic services throughout Connecticut. CHC has 204 sites located within 14 primary care hubs. The primary care hubs are located in Bristol, Clinton, Danbury, Enfield, Groton, Hartford, Meriden, Middletown, New Britain, New London, Norwalk, Old Saybrook, Stamford and Waterbury. CHC delivers primary care and BH services in more than 50 school-based health centers, and healthcare for the homeless at clinics located throughout Connecticut, mobile preventive dental services in nearly 200 schools across the state and Quick Care Clinics to help ensure that members receive timely and effective care and avoid unnecessary emergency room use.

For PCMH+, CHC utilizes a team approach designating full time, bilingual ECCs to provide enhanced care coordination activities to 41,974 PCMH+ members (61% adults and 39% children). The PCMH+ team consists of one PCMH+ dedicated ECC, seven Access-to-Care Workers, four BH ECCs, one senior RN Complex ECC, one nurse triage team leader, one chief nursing officer and 38 RN Complex ECCs (primary care RNs). The RN Complex ECC is a position that existed prior to PCMH+; these staff are also leveraged to provide PCMH+ enhanced care coordination activities to PCMH+ members. The 38 RN Complex ECCs devote a minimum of 20% of their time to providing enhanced care coordination interventions to PCMH+ members.

CHC reports the following monthly PCMH+ care coordination contacts: April 2017: 15,402 contacts; May 2017: 12,863 contacts; June 2017: 11,237 contacts; July 2017: 9,646 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	CHC utilizes Community Health Network of Connecticut (CHNCT) provider profile reports and CHNCT Care Analyzer information to supplement internal reporting and identify gaps in care. Data is used for risk stratification. Members with risk scores above 5 and/or with multiple emergency department visits are identified with an internally developed application referred to as “NOVO” and used by the member service advocates to handle member calls, schedule appointments and transfer to the Nurse Triage line.
	CHC utilizes a Performance Improvement Committee to ensure and improve quality throughout the organization. The Performance Improvement Committee is composed of a broad cross section of staff at all levels, disciplines and departments, who establish and review goals annually based on internal clinical and operations data as well as member and staff feedback.

REVIEW AREA	STRENGTH
Program Operations	CHC developed a PCMH+ Playbook to standardize operating procedures and incorporated PCMH+ program goals into their 2017-2018 Performance Improvement Plan.
	Many of CHC's sites have extended hours (until 7 pm during the week and Saturday hours); they are currently considering including Sunday hours, which is strongly encouraged.
	PCMH+ ECC outreach includes face-to-face contacts and outreach at a homeless shelter located across from an emergency department to re-direct members to primary care.
	All staff provide coordination to members if there is an identified need. Specific resource or care coordination supports can prompt a referral to the PCMH+ ECC, but coordinating care for members extends beyond the ECCs.
Physical Health-Behavioral Health Integration	BH screening is universal and conducted at least annually for members and includes a variety of screening tools covering various age groups and includes screens for substance use disorders and developmental and BH issues in children.
	Wellness Recovery Action Plan development with members is done via member lead group method, which has strong evidenced based support.
	Member interest in developing Wellness Recovery Action Plans has CHC adding even more Wellness Recovery Action Plan groups to programming and, in addition to specific Wellness Recovery Action Plan group sessions, CHC is incorporating Wellness Recovery Action Plan into already existing BH groups.
Cultural Competency	CHC has implemented "SOGI" (sexual orientation and gender identity) data collection during initial member intake while also collecting information on cultural preferences, race, ethnicity and language preferences as well as asking the member their preferred way of learning and preferred pronoun.
Community Linkages	CHC maintains a comprehensive list of community resources that includes over 145 organizations. The list addresses a variety of resource needs for individuals served by CHC.
	CHC takes part in Community Care Team meetings, which are focused on finding follow-up services for members after emergency department admissions. Additionally, CHC hosts Community Advisory Councils which identify and collaborate to identify unmet member needs.
Member File Reviews	CHC's ECCs are providing strong care coordination for members. This is evidenced by well-documented follow up by the ECC, internal coordination amongst team members (including the BH ECC if applicable), referrals and subsequent access to the necessary services and supports.
	CHC clearly collects and documents information pertaining to Children and Youth with Special Health Care Needs. Information collected includes durable medical equipment and medical supplies, school information and whether an IEP or 504 plan exists, and care coordination needs of the child and family. It is also clear CHC is actively working to obtain copies of the IEP or 504 plan directly from schools and is considering asking school-based health center staff to expand their participation in the development of IEPs.

REVIEW AREA	STRENGTH
Member File Reviews	CHC clearly collects and documents information pertaining to members with disabilities and documents these needs in the electronic health record. Information collected includes durable medical equipment and medical supplies, home health agency information and services and use of community support services.
	CHC collects and documents a robust set of cultural needs and social determinants of health under the member's social history. Information collected includes social determinants of health, language/s spoken, religious preferences, member's learning style, perception of literacy, identification of sexual orientation, gender identity, preferred pronouns and sex assignment at birth. The information is documented alongside the clinical notes.
	CHC is consistently screening members for BH.
	CHC consistently asks members about the presence of a psychiatric advance directive. If the member has a psychiatric advance directive, CHC is consistently obtaining the psychiatric advance directive for the member file. If the member does not want a psychiatric advance directive, CHC notes this in the member record.

OPPORTUNITIES

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

Please note that identification of Children and Youth with Special Health Care Needs, members with disabilities and transition age youth posed challenges for the majority of PEs and therefore the challenges identified at CHC are not unique. DSS recognizes that definitions for these populations vary and identification of these members is new for PEs under PCMH+ and not straightforward. As such, DSS suggests that these topics be items for discussion at future provider collaborative meetings.

REVIEW AREA	OPPORTUNITY
Program Operations	There has been limited member representation/ongoing participation in the PCMH+ Oversight Committee. CHC indicates only one PCMH+ member is currently participating, but CHC is taking active steps to identify additional PCMH+ members and encourage broader participation.
Children and Youth with Special Health Care Needs	CHC indicates a process to identify children with special health care needs, but this process was informal and generally documented on paper and not incorporated into the electronic health record. The review team identified this as an opportunity area to incorporate tracking and documentation methods within the electronic health record for continuity of care and reporting.
Member File Reviews	CHC is still developing procedures to fully implement Wellness Recovery Action Plans with members and ensure that documentation is reflected in member's files.

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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 National Committee for 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

- CHC developed a PCMH+ Playbook to standardize operating procedures and incorporated PCMH+ program goals into their 2017-2018 Performance Improvement Plan.
- Many of CHC's sites have extended hours (until 7 pm during the week and Saturday hours); they are currently considering including Sunday hours, which is strongly encouraged.
- Provider profile reports and Care Analyzer member risk information provided by the HUSKY Administrative Services Organization-CHNCT are used to supplement CHC's internal reporting, to identify member's gaps in care and for risk stratification of their members. Members with high risk scores and/or more than three emergency department visits, or who had an inpatient stay in the last 30 days are identified with an internally developed application referred to as "NOVO" and are referred to the PCMH+ ECCs for outreach and support.
- CHC's electronic health record, eClinicalWorks, tracks and flags 35 gaps in care such that all staff can easily identify that a member is due for a health service and either schedule the appointment or refer the member to the ECCs for outreach and follow-up.
- CHC's Performance Improvement Committee is responsible for ensuring the quality of all of the clinical, administrative, financial, safety, and operational elements of CHC and is charged with overseeing an agency-wide quality improvement infrastructure that is used to continuously improve quality across the agency and achieve the goals of the annually updated Performance Improvement Plan. Reporting to the Performance Improvement

Committee, the PCMH+ Oversight Committee was recently established to ensure that CHC is reflecting the unique interests and needs of PCMH+ membership. The PCMH+ Oversight Committee meets quarterly, and includes representation of two members that have participated actively in both meetings to date. CHC realized during the second meeting that only one is a PCMH+ attributed member and are taking steps to immediately resolve this and identify current PCMH+ members and encourage participation. CHC provides assistance, such as childcare and transportation for PCMH+ members to attend these meetings.

- All staff provide coordination to members if there is an identified need. Specific resource or care coordination supports can prompt a referral to the PCMH+ ECC, but coordinating care for members extends beyond the ECCs.
- CHC has 41,974 PCMH+ members assigned. Based on their PCMH+ Monthly Provider Reports submitted to DSS, there have been 15,402 care coordination contacts in April 2017, 12,863 care coordination contacts May 2017, 11,237 care coordination contacts in June 2017 and 9,646 care coordination contacts in July 2017. CHC's reporting system counts all care coordination contacts with a member, done by any staff, not just PCMH+ ECCs but reported they have the ability to report care coordination contacts that are specific to PCMH+ staff and assigned members.
- PCMH+ ECC outreach includes face-to-face contacts, and outreach at a homeless shelter located across from an emergency department to re-direct members to primary care.
- CHC has reported that they have had 15,095 PCMH+ members screened for a BH condition during the months of April 2017—June 2017. Consistent screening for BH conditions was noted during the member file review.

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.
- CHC developed an underservice prevention policy, supporting PCMH+ and CHC's broader programs that specifically addresses potential panel manipulation, evaluates complaints and grievances that could indicate underservice issues, details strict guidelines on member terminations and prohibits rewards to providers for reducing services to members. The policy was approved June 25, 2017 and shared with their staff.

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

- BH screening is universal and conducted at least annually for members using PHQ2/9 and CHC has broadened their screens 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.), PSC-17 (Pediatric Symptom Checklist that identifies psychosocial issues in children), MCHAT (developmental screening tool for toddlers between 16 and 30 months of age) and ACES (adverse childhood experiences questionnaire). Evidence of universal screening was noted during the file review.
- Members screening positive receive a warm hand-off during their visit to meet the BH team and schedule a formal BH assessment.
- CHC has a process to ask members about psychiatric advanced directives, but with limited use across membership have elected to include crisis components of a psychiatric advance directive into the Wellness Recovery Action Plan tool.
- Wellness Recovery Action Plan development with members is done via member lead group method, which has strong evidenced based support.
- Member interest in developing Wellness Recovery Action Plans has CHC adding even more Wellness Recovery Action Plan groups to their programming and, in addition to specific Wellness Recovery Action Plan group sessions, CHC is incorporating Wellness Recovery Action Plan into already existing BH groups.
- Integrated team meetings are conducted to review member cases. Results of these meetings are documented in the member's file for all team members to access and follow-up action items are created to address and close the identified issue(s).
- Building transition age youth plans of care is under development and nearing completion. Targeting youth starting at age 12 and developing a transition age youth plan of care that

can follow the child. CHC currently uses a self-assessment form that is completed by the youth/family.

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+ CYSHCN 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

- CHC indicates a process to identify children with special health care needs, but this process was informal and generally documented on paper and not incorporated into the electronic health record. The review team identified this as an opportunity area to incorporate tracking and documentation methods within the electronic health record for continuity of care and reporting. In addition, CHC is in the process of creating a shared plan of care that will be shared with the member/family and across all disciplines caring for the member.
- CHC is piloting a process to routinely request IEPs and/or 504 plans from parents.

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.
- 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

- Members are assessed for medical equipment and medical supply needs, home health agency information and use of community support services.
- Staff are trained on managing members who are medically fragile and/or have disabilities and the education information is shared in grand rounds with staff.
- Various accommodations are made for members with disabilities throughout CHC's sites including: adjusting lighting for those sensitive, extended appointments, adjustable exam

tables, speaker phones and video capabilities in exam rooms for interpretation calls, and recent additions of wheel-chair scales.

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

- CHC holds cultural competency training annually and at onboarding as well as holds a separate training on treating individuals with disabilities. Attendance at the two-hour training is mandatory with make-up sessions being provided as needed.
- CHC has a robust plan in place implementing CLAS standards at governance, leadership and workforce levels. Community Health has developed the "eConsult" model to address the difficulty that non-English speaking members face when accessing specialty care. This model makes an electronic consult between the primary care provider and the specialist the "first pass" consultation, reducing the number of members who must go in person for a visit to the specialist.
- CHC has implemented "SOGI" (sexual orientation and gender identity) best practice data collection during initial member intake. CHC screens for cultural preferences and collects information regarding race, ethnicity and language preferences as well as asking the member their preferred way of learning and preferred pronoun.

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

- CHC has developed a comprehensive list of over 145 community resources that includes partnerships with organizations that provide services such as housing, food assistance, employment, transportation, mental health and addiction, literacy and senior services.

- Other relationships include soup kitchens, homeless shelters, domestic violence shelters, an urban farm and farmer's market, visiting nurses, adult-serving and child-serving organizations, justice-related groups, social service agencies, public health entities, and Connecticut 211, which provides broad linkages to a variety of local services. Additionally, CHC invited 211 representatives to conduct in-depth staff training regarding the offerings and the online search tools.
- Access to Care staff identify non-clinical resources in their local communities for members and their families and assist members in obtaining needed resources. Other care team members, including the PCMH+ ECCs, primary care providers, nurses and dieticians, share information with members about community resources during member visits.
- CHC hosts Community Advisory Councils comprised of representatives of a variety of community-based organizations. One function of the group is to identify and collaborate to manage unmet member needs.
- In addition, CHC takes part in Community Care Teams, which are based out of many emergency departments and which help members attain needed follow-up services in the community, such as those focused on mental health or substance use.

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 health record, CHC 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).
- Member's 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.

Reviewers included two Mercer representatives and two DSS representatives who reviewed a total of 26 member files. Some files were provided in hard copy and others were available on thumb drives. All of the files contained dates of service and non-solicited documents that were not required as part of the review. One file contained information only from calendar year 2014 and another three files contained information for same member. The majority of the information provided did not provide evidence of CHC's compliance with PCMH+ requirements as the majority of the files were members who had not received PCMH+ care coordination contacts or PCMH+ interventions such as BH screens or resource assessments.

B. Member File Review Findings

- Files included evidence of ECCs care coordination for members including well-documented follow up by the ECC, internal coordination amongst team members (including the BH ECC if applicable), referrals and subsequent access to the necessary services and supports.
- Information pertaining to Children and Youth with Special Health Care Needs was evident. Information collected includes durable medical equipment and medical supplies, school information and whether an IEP or 504 plan exists, and care coordination needs of the child and family. It is also clear CHC is actively working to obtain copies of the IEP or 504 plan.
- There was evidence members with disabilities are assessed. Information collected includes durable medical equipment and medical supplies, home health agency information and services and use of community support services.
- CHC collects and documents cultural needs and social determinants of health under the member's social history. Information collected includes social determinants of health, language/s spoken, religious preferences, member's learning style, member's perception of literacy, identification of sexual orientation, gender identity, preferred pronouns and sex assignment at birth. The information is documented alongside the clinical notes.
- There was evidence of consistent screening of members for BH conditions.

- There was consistent evidence of obtaining the psychiatric advance directive for the member file. If the member does not want a psychiatric advance directive, CHC notes this in the member record.
- CHC is still developing procedures to fully implement Wellness Recovery Action Plans with members.

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

CHC arranged two interviews with PCMH+ assigned members, both in person.

- Both members were receiving PCMH+ enhanced care coordination interventions, which was confirmed by CHC.
- The members knew who their ECCs were and were able to easily connect by phone when needed. Both members emphasized that they notice a difference in their care experience due to the ECCs interventions. The ECCs educated both members about available services such as assistance with housing, food banks, etc. One member participated in housing assistance but was already well versed in community resources and did not require additional help. The other member knew of other members who were also assisted with their housing issues.
- One member participates on the PCMH+ Community Advisory Committee but has only attended one meeting so far. Her ECC provides her with materials for the board in Spanish since English is her second language. The member stated she thinks board participation is important to the community to ensure better service. The other member has participated in the PCMH board for 14 years.
- Neither member had issues accessing medical care. Both agree that their providers show an interest in their care. One stated she can call or come into the center whenever she desires and she feels comfortable switching providers she does not care for. The other appreciated the fact that her providers were in the same building. The member also mentioned that when her husband asked for a specialist closer to their home rather than the one originally referred, the provider accommodated the request.

- One of the members valued the care coordination and related that her ECC prompted her for dental care when she came into the center for a medical visit.
- Neither member was familiar with the process to file a complaint. If they have a complaint, though, each felt comfortable discussing their issue with staff members.

APPENDIX A

COMMUNITY HEALTH CENTER RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	There has been limited member representation/ongoing participation in the PCMH+ Oversight Committee. CHC indicates one PCMH+ member is currently participating, but are taking active steps to identify additional PCMH+ members and encourage broader participation.	Continue efforts to identify PCMH+ members willing to serve on the PCMH+ Oversight Committee. Ensure there is substantial representation by PCMH+ members as required.
Children and Youth with Special Health Care Needs	CHC indicates a process to identify Children with Special Health Care Needs, but this process was informal and generally documented on paper and not incorporated into the electronic health record. Identified this as an opportunity area to incorporate tracking and documentation methods within the electronic health record for continuity of care and reporting.	Develop mechanisms to identify Children with Special Health Care Needs and ensure assessed needs are incorporated in the member's plan of care and accessible to all treating staff.
Member File Reviews	CHC is still developing procedures to fully implement Wellness Recovery Action Plan with members.	Formalize procedures to fully implement the Wellness Recovery Action Plan process for members.

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