HEALTH WEALTH CAREER

2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF GENERATIONS FAMILY HEALTH CENTER

AUGUST 30, 2017

CONTENTS

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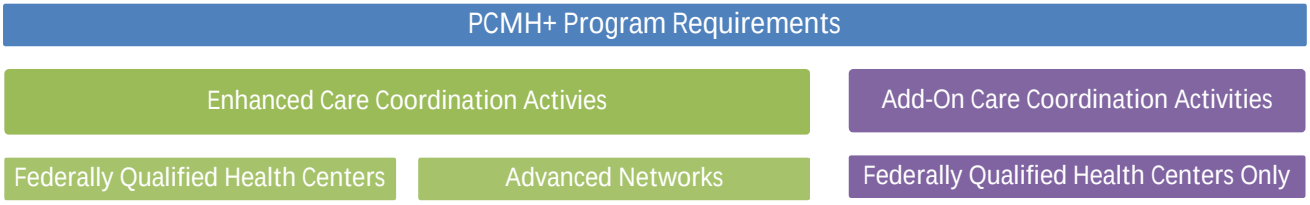
INTRODUCTION

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.

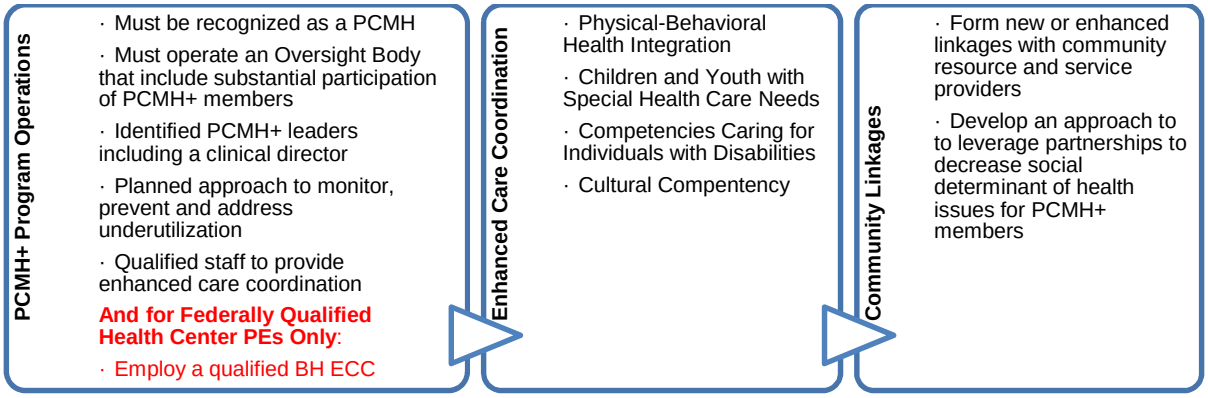
DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite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

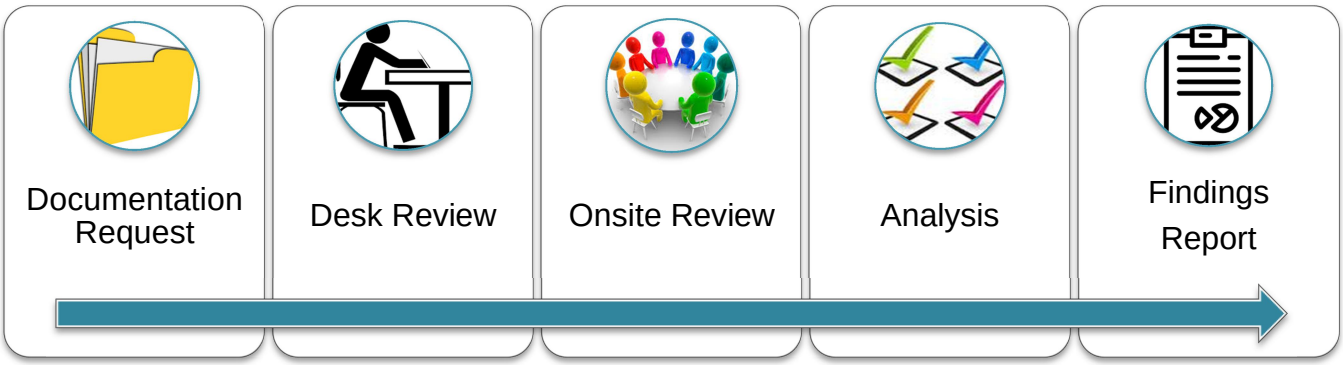


For PEs, like Generations Family Health Center (GFHC) that are a federally qualified health center, there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice, including a qualified BH enhanced care coordinator (ECC) on staff who is an active participant in the GFHC'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 GFHC took place on August 30, 2017, at the offices located in Willimantic, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff and appropriate GFHC 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 GFHC staff:

- Arvind Shaw — CEO
- Missy Bonsall — COO and Senior Leader
- Mort Glasser — CMO
- Deb Savoie — CFO
- Danielle DiGeronimo — CQO, Clinical Leader
- Jennifer Mendos-Hramiak — Chief BH Officer
- Fran Boulay — Medical Operations Director
- Ann Gueutal — BH Operations Director
- Aditi Gohil — BH Clinical Supervisor
- Kerri McAvay-Redner — BH Clinical Supervisor
- Judi Gaudet — System of Care Manager

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

GFHC PCMH+ PROGRAM OVERVIEW

GFHC is a federally qualified health center serving 37, mostly rural, towns in eastern Connecticut. GFHC provides a full continuum of primary care and specialist care to its members including: BH, chronic disease management, dental and offers extended hours throughout the week (until 8 pm). Additional services include community outreach, health education and enrollment services, a mobile dental clinic, one school-based health center and enhanced access and services for the homeless, farmworkers, children with special healthcare needs and HIV/AIDS/Hepatitis C members.

Under PCMH+, GFHC provides enhanced care coordination activities to 7,465 PCMH+ members (4:1 adults to children). Staffing for PCMH+ includes six full-time bilingual ECCs, who are 100% dedicated to the PCMH+ program; two of these staff serve as the BH ECC. GFHC has assigned one ECC to each of their six sites. All ECCs report to the System of Care Manager who supervises the team and provides program oversight.

GFHC hopes to limit each ECC to a working panel of an estimated 100 PCMH+ members. The System of Care Manager will maintain the PCMH+ member panels and ensure that members not engaged in care coordination will be reviewed for discharge when appropriate, to allow for another member to benefit from the program. As of the July PCMH+ Monthly reporting, GFHC reports the following monthly care coordination contacts: April 2017: 5 contacts; May 2017: 51 contacts; June 2017: 31 contacts; July 2017: 167 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	GFHC has developed a Care Level Assessment tool which uses a point system for risk stratification to identify members with the highest needs. Identified members are targeted for outreach for ECC supports.
Physical Health-Behavioral Health Integration	GFHC conducts BH screenings beyond depression. Screening tools include: PHQ-2/9, PHQ-A (BH screen for adolescents), ASQ-3 (pediatric developmental screen for ages 1 month to 5 years), MCHAT-R (pediatric assessment for autism), Pediatric Symptom Checklist (PSC) (pediatric developmental screen for school-age children) and CAGE-AID (substance use disorder screen). GFHC reported that 3,480 PCMH+ members were screened for BH conditions during the months of April 2017—June 2017.
	For members screening positive for BH conditions, GFHC utilizes a warm hand off process to ensure members are connected quickly to a BH staff person.
	GFHC has developed a psychiatric advance directive utilized by the BH department. Members/families without psychiatric advance directives who express interest are assisted with psychiatric advance directive development.

REVIEW AREA	STRENGTH
Physical Health-Behavioral Health Integration	GFHC utilizes the nationally-recognized Wellness Recovery Action Plan developed by Mary Copeland. GFHC utilizes both individual and group sessions to develop Wellness Recovery Action Plans.
	GFHC is actively working to increase provider competencies in Wellness Recovery Action Plan processes.
	A Care Level Assessment is used to identify risks and stratify the member population includes an assessment for social determinants of health, BH needs, an activity of daily living/instrumental activities of daily living assessment and language and literacy needs.
	GFHC has developed a specialized care plan for transition age youth. The plan comprehensively addresses the needs of transition age youth and addresses needs such as medical care, dental care, employment services, housing needs, insurance assistance, substance abuse needs, current legal involvement, Department of Child and Family involvement, disability/DSS paperwork needs, transportation needs and social supports, spiritual and cultural needs.
Children and Youth with Special Healthcare Needs	GFHC offers to develop advanced directives with all families of Children and Youth with Special Health Care Needs.
	GFHC maintains a strong presence in the local schools. The Children and Youth with Special Health Care Needs ECCs assist families with the special education process and will attend individualized education plan meetings, if needed, to provide advocacy. The ECCs will also assist the families to file grievances if needed to ensure members receive the necessary accommodations.
Competencies in Care for Individuals with Disabilities	GFHC captures the needs of members with disabilities through the Care Level Assessment. This assessment includes an evaluation of activities of daily living, durable medical equipment and other adaptive needs and home health needs.
Cultural Competency	GFHC ensures the use of certified medical interpreters by offering in-house certification training to bilingual employees. GFHC currently has 22 employees certified as medical interpreters who serve a highly diverse member population in which over 300 languages are spoken. The training will be offered to new employees on an as needed basis.
	GFHC collects a robust set of cultural needs and preferences on the Care Level Assessment such as sexual and gender identity, preferred pronouns and naming, preferred methods for learning, cultural beliefs that would prevent certain treatment, religious beliefs, household structure and literacy needs.
	GFHC shows a strong commitment to employing a diverse workforce that matches the diversity of their membership. For example, GFHC has hired two physicians from Mexico, who work primarily with Spanish-speaking members and who bring a unique perspective to their workforce.
Community Linkages	As noted above, the GFHC utilizes the Care Level Assessment on all members that highlights individual member resource needs, screens for social determinants of health, BH needs, language and literacy needs and includes an activity of daily living assessment.
	GFHC participates in monthly community care team meetings in collaboration with other community providers. The meeting has a dual purpose: 1) to collectively discuss and address the needs of mutually-served members and 2) to support collaborative efforts of the federally qualified health center and community partners.

REVIEW AREA	STRENGTH
Member File Reviews	There was evidence of comprehensive assessments that include identification of social determinants of health and member centric plans of care consistent with the assessments.
	Coordination of care was evident in the files reviewed including community linkages to services such as housing, transportation and assistance with applications and paperwork.
	There was evidence of BH integration. Referrals are made from physical health providers for BH services and Wellness Recovery Action Plan services were offered to members with BH needs.

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 GFHC are not unique. The Department 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	The GFHC quality program plan does not include the PCMH+ program or how the PCMH+ program is evaluated or contributes to GFHC's quality goals.
	Enhanced care coordination member penetration rates are low for the 7,465 assigned PCMH+ membership, but appear to be trending upward. GFHC reports the following monthly care coordination contacts: April 2017: 5 contacts; May 2017: 51 contacts; June 2017: 31 contacts; July 2017: 117 contacts.
Underservice	While there was no evidence of underservice noted during the review, DSS recommends that all PCMH+ PEs develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.
Competencies in Care for Individuals with Disabilities	GFHC's current definition of disability is limited to those deemed as disabled by the Social Security Administration (SSI). GFHC is working with DSS to expand this definition to be more inclusive of other disabilities which may not meet these federal eligibility criteria.

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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

- GFHC has developed a Care Level Assessment tool which uses a point system for risk stratification. To determine an overall risk score, the tool evaluates areas such as clinical, psychosocial, utilization and social determinants of health and assigns points. Members receiving a high risk score are assessed/offered care coordination services, and if agreed upon, an ECC is assigned to the member and this service is identified in the member's electronic health record.
- Provider profile reports and Care Analyzer member risk information provided by the HUSKY Administrative Services Organization-CHNCT are incorporated into the PCMH+ member's care plan in terms of member education and/or follow-up care needed to close gaps in care.
- The oversight body at GFHC is the Quality Subcommittee of the Board of Directors at Generations. This committee includes the Chief Quality Officer (Clinical Leader on PCMH+), the Chief Operating Officer (Senior Leader on PCMH+), the Chief Executive Officer, and five members of the Board of Directors, three of which are PCMH+ members. The Quality Subcommittee of the Board of Directors (i.e., PCMH+ Oversight Body) meets every two months, and reviews current progress and planned activities. Currently, there are four PCMH+ members attending.
- GFHC has a quality program which includes annual goals, the scope of the performance improvement plan, a description of the FOCUS-PDSA model, governance body structure and responsibilities and quality improvement activities. The quality program plan does not

include the PCMH+ program or how the PCMH+ program is evaluated or contributes to GFHC's quality goals.
- Enhanced care coordination member penetration rates are low for the 7,465 assigned PCMH+ membership, but appear to be trending upward. GFHC reports the following monthly care coordination contacts: April 2017: 5 contacts; May 2017: 51 contacts; June 2017: 31 contacts; July 2017: 117 contacts.

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.
- The System of Care Manager runs monthly reporting to track provider referrals for specialty care to identify trends in underservice. In addition, the PCMH+ leadership team reviews membership data monthly to evaluate increases and decrease in visits.
- GFHC submitted an "Access to Care" policy that outlines broad efforts to ensure member access to services and care.

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 health challenges.
- For federally qualified health centers only: Develop Wellness Recovery Action Plans in collaboration with the member and family.

B. PH-BH Integration Findings

- GFHC's BH department conducts BH screenings beyond depression. Screening tools include: PHQ-2/9, PHQ-A (BH screen for adolescents), ASQ-3 (pediatric developmental

screen for ages 1 month to 5 years), MCHAT-R (pediatric assessment for autism), Pediatric Symptom Checklist (PSC) (pediatric developmental screen for school-age children) and CAGE-AID (substance use disorder screen). GFHC reportedly screened 3,480 PCMH+ members for BH conditions during the months of April 2017—June 2017.

- GFHC utilizes a warm hand off process to ensure members who screen positive for BH are connected quickly to a BH staff person or assist with a referral to BH services. Referrals are entered a queue which is reviewed daily for follow up. GFHC provides some BH services, but refers out for substance use disorder services and reports the community provides a full continuum of substance use disorder services.
- GFHC has developed a psychiatric advance directive which is utilized by the BH department. GFHC has a policy and procedure in place requiring that all BH members are asked whether they have a psychiatric advance directive, or they provide the necessary information and forms for members interested in developing a directive.
- GFHC utilizes the nationally-recognized Wellness Recovery Action Plan developed by Mary Copeland and has woven the document into the BH plan. The Wellness Recovery Action Plan is developed individually and through group sessions by the BH clinicians in collaboration with members.
- GFHC is actively working to increase provider competencies in Wellness Recovery Action Plan processes. Providers have participated in training and receive peer-to-peer support from fellow colleagues to increase their skill sets.
- A Care Level Assessment is conducted on all members to develop an overall risk stratification for the member population. In addition, this assessment identifies transition age youth, members eligible for care coordination services, highlights individual member needs, assists in measuring and reporting member health outcomes and includes an assessment for social determinants of health, BH needs, an activity of daily living/ instrumental activities of daily living assessment and language and literacy needs.
- GFHC has developed a specialized care plan for transition age youth. The plan comprehensively addresses the needs of transition age youth and addresses needs such as medical care, dental care, employment services, housing needs, insurance assistance, substance abuse needs, current legal involvement, Department of Child and Family involvement, disability/DSS paperwork needs, transportation needs and social supports, spiritual and cultural needs. It is being piloted with BH members with the goal to implement with physical health members at a later stage.
- GFHC holds interdisciplinary team meetings that include the BH ECCs at least once monthly with a goal of weekly meetings. The team includes both physical health and behavioral health representatives who develop action plans and have established follow-up procedures to ensure the member's needs are addressed.

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

- GFHC has been part of a Children and Youth with Special Health Care Needs grant for many years and has two ECCs specifically assigned to support this population. They use the CT Medical Home Initiative Children and Youth with Special Health Care Needs screener to identify Children and Youth with Special Health Care Needs.
- GFHC offers to develop advanced directives with all families of children with special health care needs and includes advanced directives in the member record.
- Full health assessments on Children and Youth with Special Health Care Needs are conducted as well as a shared plan of care (developed in collaboration with the CT Department of Public Health) which captures diagnoses, familial challenges, home health and school needs.
- GFHC maintains a strong presence in the local schools with ECCs assisting families, attending IEP meetings if needed to provide advocacy or assistance filing grievances if needed to ensure members receive the necessary accommodations in the school setting.

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

- GFHC's current definition of disability is limited to those deemed as disabled by the SSI. GFHC is working with DSS to expand this definition to be more inclusive of other disabilities which may not meet these federal criteria.
- GFHC captures the needs of members with disabilities through the Care Level Assessment. This assessment includes an evaluation of activity of daily living, durable medical equipment and other adaptive needs and home health needs.

- GFHC has a previously established policy to accommodate longer appointment times for members with disabilities.
- GFHC has adaptive equipment to meet the needs of members with disabilities including lower exam beds and wheelchair scales. GFHC identifies member needs ahead of appointment times to ensure the equipment is available for them at the time of the appointment.

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

- All GFHC staff receive cultural competency training when hired and annually thereafter. Training on cultural considerations for members with disabilities is woven throughout the other onboarding trainings.
- GFHC ensures the use of certified medical interpreters by offering in-house certification training to bilingual employees. GFHC currently has 22 certified employees who serve a highly diverse member population in which over 300 languages are spoken. The training will be offered to new employees on an as needed basis.
- GFHC collects a robust set of cultural needs such as sexual and gender identity, preferred pronouns and naming, preferred methods for learning, cultural beliefs that would prevent certain treatment, religious beliefs, household structure, literacy needs and preferences on the Care Level Assessment. Critical cultural needs are included under the electronic health record alert system to ensure they are brought to the attention of all team members. Cultural needs are re-assessed through regular visits.
- GFHC shows a strong commitment to employing a diverse workforce that matches the diversity of their membership. For example, GFHC has hired two physicians from Mexico who work primarily with Spanish-speaking members and who bring a unique perspective to their workforce.

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

- GFHC maintains a comprehensive list of community partnerships that meets the needs of members and if a member presents with a need that cannot be met by the current list of community linkages, GFHC has a process to seek new partnerships to meet those needs. All team members have access to the site and can update the list as needed
- The Care Level Assessment highlights individual member resource needs, screens for social determinants of health, BH needs, language and literacy needs and includes an activity of daily living assessment.
- GFHC uses a referral tracking system within the electronic health record to close the loop on all referrals made to community linkages. This system is monitored by the staff coordinating the referrals, as well as the providers who initiated the referrals.
- GFHC participates in a monthly community care team meeting in collaboration with other community providers. The meeting has a dual purpose: 1) to collectively discuss and address the needs of mutually-served members and 2) to support collaborative efforts of the federally qualified health center and community partners. Members must sign a written consent for their information to be shared at these meetings.

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, 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).
- 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 who reviewed a total of 20 member files.

B. Member File Review Findings

- Files consistently included comprehensive member assessments that includes social determinants of health and contained plans of care consistent with the assessments.
- Physical health and behavioral health integration, including BH referrals and assessments, was evident in the files reviewed.
- Files included member's cultural needs including gender identity and sexual orientation.
- Documentation demonstrated active linkage of members to community resources, assistance with paperwork, appointments, and transportation for members.
- One file reviewed contained evidence of a Wellness Recovery Action Plan in the process of development. GFHC shared that Wellness Recovery Action Plans are not included in files until they are completed, but Wellness Recovery Action Plans in progress were mentioned in clinical notes.
- There was evidence that staff consistently ask members about the presence of a psychiatric advance directive.

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

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

- Both members were receiving PCMH+ enhanced care coordination and reported they could easily connect with their ECCs by phone when needed including one member who indicated she has her ECC's number and business card.
- Neither member currently participates on the PCMH+ community advisory committee but one held a position on the GFHC's oversight board and has been a member for eight years. This member believes it is important for members to be active in their health care and to be aware of what is available in the community. This member said that whenever an issue is brought up by a member, the issue is accomplished by the next board meeting or even by the next day. "We are heard; we are listened to."
- Both members were confident about the process to file complaints. One of the members stated there were comment forms at the front desk to fill out and also that she felt free to complain at board meetings. The other stated he would complain to a staff person if necessary. Neither member had any complaints with their ECCs or with their providers. One of the members had an issue with a transportation vendor and complained. He shared his issue was resolved.
- Neither member had issues accessing medical care, BH, dental or specialty services. One of the members also mentioned he was able to request and receive morning appointments with no problem.
- The members shared that ECCs support them in obtaining medical appointments and assist with non-medical supports such as obtaining a driver's license, ordering and purchasing prescriptions, accessing legal aid and attending nutrition and smoking cessation classes.

APPENDIX A

GENERATIONS FAMILY HEALTH CENTER RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	The GFHC quality program plan does not include the PCMH+ program or how the PCMH+ program is evaluated or contributes to GFHC's quality goals.	GFHC is encouraged to include the PCMH+ program and evaluation efforts in future iterations of the quality plan.
	Enhanced care coordination member penetration rates are low for the 7,465 assigned PCMH+ membership, but appear to be trending upward. GFHC reports the following monthly care coordination contacts: April 2017: 5 contacts; May 2017: 51 contacts; June 2017: 31 contacts; July 2017: 117 contacts.	Evaluate current PCMH+ enhanced care coordination member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities.
Underservice	While there was no evidence of underservice noted during the review, DSS recommends that all PCMH+ PEs develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.	Develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested
Competencies in Care for Individuals with Disabilities	GFHC's current definition of disability is limited to those deemed as disabled by the SSI.	Continue to work with DSS to refine the definition of members with disabilities.

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