HEALTH WEALTH CAREER

2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF OPTIMUS HEALTH CARE

AUGUST 7, 2017

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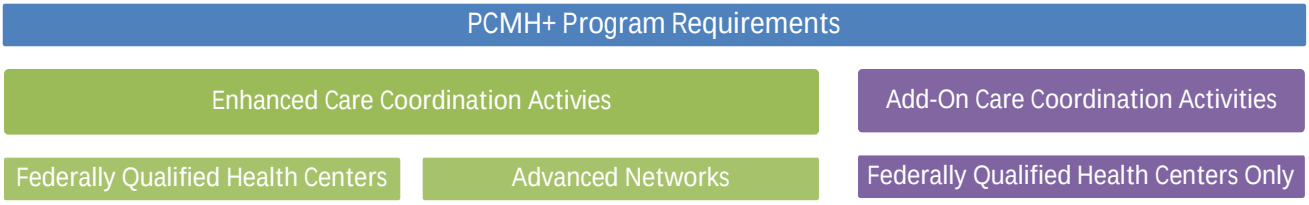
INTRODUCTION

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.

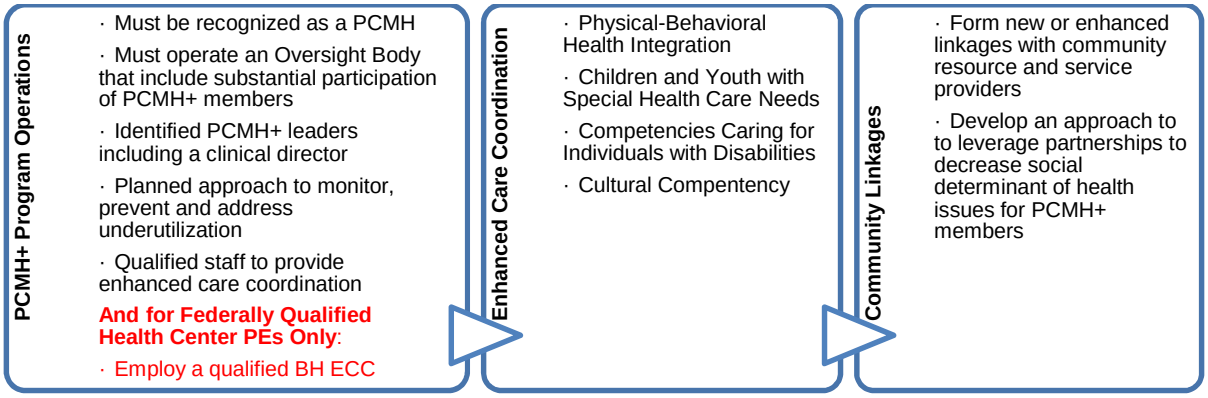
DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite 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 Optimus Health Care (OHC) 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 (BH ECC) on staff who is an active participant in the OHC'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 component of the review for OHC took place on August 7, 2017, at their 982 E. Main Street, Bridgeport, Connecticut office. The onsite review began with an introductory session with the

Mercer team, DSS staff and appropriate OHC 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 OHC staff:

- Nelly Angah — PCMH Project Manager
- Dr. Karin Michels-Ashwood — Senior PCMH+ Lead, Chief Medical Officer
- Michelle Rodriguez — Practice Manager
- Dr. Norma Kirwan — BH Team Lead, Director of BH Programs
- Jose Latorre — PCMH+ Clinical Lead, General Medicine Provider
- Margarita Torres — Chief Compliance Officer
- Justin Markowski — QA Data Analyst
- Taylor Edelmann — ECC/Community Health Worker
- Kislene Bosse — 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

OHC PCMH+ PROGRAM OVERVIEW

OHC is a federally qualified health center providing community primary care, BH and dental services. OHC operates 18 sites in Bridgeport, one site in Stratford, two sites in Milford, five sites in Stamford and 10 school-based health centers in both Bridgeport and Milford, and serves a largely Hispanic population. OHC provides enhanced care coordination activities to 19,962 PCMH+ members (with a mix of 51% children and 49% adults).

In providing PCMH+ enhanced care coordination, OHC utilizes a bilingual staff of four full-time Registered Nurse BH ECCs and six full-time ECCs/Community Health Workers, who are dedicated 100% to the PCMH+ program at their six largest sites. The PCMH+ Senior Program Lead is also the director of Quality Improvement, and oversees the PCMH+ program structure and operations. The Senior Clinical Lead oversees the application of the targeted clinical measures under the PCMH+ initiative and the integration of the PCMH+ staff into care teams. The BH Team Lead oversees the integration of the PCMH+ initiative within the BH Team. The Chief Medical Officer oversees the three Senior Lead positions.

OHC has a Performance Improvement Committee which serves as their PCMH+ oversight body. The Performance Improvement Committee has met monthly with the exception of a combined July–August meeting. Performance Improvement Committee members include representatives from all departments and clinical and management, but at this point does not include a member representative. The Performance Improvement Committee oversees the organization's performance measurement and quality improvement initiatives by receiving input from the various committees and individuals at Optimus Healthcare Inc. and other appropriate resources from within and outside the organization. The Performance Improvement Committee reports to the Senior Executive Committee, which reports to the Board of Directors.

OHC reports the following PCMH+ care coordination contacts for their 16,294 assigned PCMH+ membership: April 2017: 27 contacts; May 2017: 72 contacts; June 2017: 137 contacts and July 2017: 272 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	OHC utilizes provider profile reports and Care Analyzer information to compare against the OHC's data management software to identify the most at risk members. This information is disseminated to the Practice Managers so the staff can promptly follow up to close gaps in care.
	OHC has a robust quality program which includes annual goals, committee structure, quality assurance assessments, performance improvement policies and procedures, audit tools, a quality work plan and gives an overview of the governance body and describes how various subcommittees support the larger body.

REVIEW AREA	STRENGTH
Program Operations	OHC conducted targeted staff training around suicide prevention, bullying and gang violence.
Physical Health-Behavioral Health Integration	OHC plans to develop Wellness Recovery Action Plans using a group model and will hire a specialized ECC to manage these groups. OHC has begun the interview process and targets approximately six weeks from the onsite review to fill the position.
Competencies in Care of Individuals with Disabilities	OHC's electronic health record "flags"/identifies members who have communication barriers and members who require longer appointments. Members have access to interpreters and extended appointment times to accommodate their needs.
Cultural Competency	OHC has self-identified "stereotyping" as a training area for future iterations of cultural competency staff training.
Community Linkages	OHC maintains a robust list of community resources that includes over 23 organizations. The list comprehensively addresses the needs of individuals served by OHC.
	During bi-weekly meetings, ECCs share key needs of PCMH+ members, discuss ways to assist members in need, identify potential community partners and ways to establish formal community partnerships.
	ECCs have developed relationships with community partners through attendance at local community collaborative meetings.
Member File Reviews	ECCs are successful in helping members to coordinate a variety of needs and clearly document member communications, contacts and follow through 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 OHC are not unique. DSS recognizes that definitions for these populations vary and identification of these members is both 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 oversight body meetings. OHC's May and June PCMH+ monthly reports indicated no PCMH+ member was in attendance.
	Enhanced care coordination member penetration rates, relative to the 16,294 assigned PCMH+ members, are low. OHC reports the following monthly care coordination contacts: April 2017: 27 contacts; May 2017: 72 contacts; June 2017: 137 contacts; July 2017: 272 contacts.
Physical Health-Behavioral Health Integration	BH screenings are not consistently documented. OHC is in process of identifying appropriate screening tools for use with adolescent and pediatric populations.

REVIEW AREA	OPPORTUNITY
Children and Youth with Special Health Care Needs	There is currently no formal process to identify Children and Youth with Special Health Care Needs, to obtain individualized education plan (IEPs), 504 plans, or conduct advanced care planning.
Member File Reviews	There is limited evidence of consistent practices for developing member plans of care, for conducting universal BH screening and how cultural needs are incorporated into the member's care plan.
	There is limited evidence of consistently asking members if they have a psychiatric advance directive.

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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 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

- Provider profile reports and Care Analyzer information provided by the HUSKY Administrative Services Organization-CHNCT are downloaded and filtered to support population management. Report information is discussed in morning huddles with other members of the healthcare team. Data from the reports are used to compare against the OHC's data management software (Practice Analytics) for filtering of most at risk members. This information is disseminated to the Practice Managers so staff can promptly follow up to close gaps in care.
- OHC held Performance Improvement Committee meetings in May, June and July. No PCMH+ members participated. OHC shared frustration regarding lack of success in recruiting PCMH+ members to the Performance Improvement Committee despite significant efforts to recruit, educate, and remove barriers including arranging transportation and offering food. PCMH+ member recruitment technical assistance was provided during the onsite review. Technical assistance included ways to contact current PCMH+ care coordination members, building trusted relationships between the ECC and the member, educating members regarding the function of the advisory board and continuing efforts to reduce barriers restricting member attendance.
- In an additional effort to obtain PCMH+ member input, OHC conducts member focus groups, and reports participation of three PCMH+ members in the focus group meetings. They are targeting these members for participation on the Performance Improvement Committee.
- OHC has a quality program which includes annual goals, a committee structure, quality assurance assessments, performance improvement policies and procedures, audit tools and

a quality work plan. The quality program provides an overview of the governance body as well as describing how various subcommittees support the larger body.
- Monthly PCMH+ reports submitted to DSS, note 27 care coordination contacts in April 2017, 72 care coordination contacts May 2017, 137 care coordination contacts in June 2017 and 272 contacts in July 2017.
- OHC reports that 158 PCMH+ members were screened for BH conditions from April 2017–June 2017.
- OHC conducted targeted staff training around suicide prevention, bullying, and gang violence.

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.
- OHC developed an underservice policy that tracks provider panels and health disparities across the organization.

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

- OHC has developed a process for the ECCs to screen for BH and substance use disorders using PHQ-2/PHQ-9 to screen for depression, GAD-7 to screen for anxiety, and substance use disorders using CAGE-AID. OHC reported internal tracking showed 97% of PCMH+

members received at least a PHQ-2 screen; however, there was limited evidence of universal screening in the member files reviewed.
- OHC is investigating appropriate screening tools for their adolescent and child populations.
- OHC plans to develop Wellness Recovery Action Plans using a group model. While there are no plans to include family and support persons in the groups, Wellness Recovery Action Plan building will integrate the member's identified "Faith, Family and Friends".
- OHC indicated they will hire a specialized ECC to manage the Wellness Recovery Action Plan groups and has begun the interview process. OHC targeted approximately six weeks from the onsite review to fill the position.
- OHC is working to develop Wellness Recovery Action Plans that are integrated within their electronic health record. In the interim, ECCs scan completed Wellness Recovery Action Plans and save them into the member's electronic health record.
- The ECCs work within an integrated Primary Care/BH Team Model that stresses warm handoffs to the ECC when the member is seen for services.
- ECCs share key needs of PCMH+ members during bi-weekly huddles. During the meeting, the ECCs identify potential community partners with which to establish formal partnerships. Currently, discussions and decisions/recommendations regarding member needs are not documented within the members file. OHC agreed that including notes from the bi-weekly huddle in the member file is a best-practice that they would like to include in the operational processes.

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+ requirements in this area 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

- OHC identified this is a growth area and plan to leverage their school based health centers to support identification of Children and Youth with Special Health Care Needs.
- OHC is developing processes to identify this population, or to obtain IEPs and 504 plans and conduct advanced care planning.

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

- OHC flags identify members within their electronic health record who have communication barriers (deaf or mute) and members who require longer appointments. OHC provides member access to interpreters and extended appointment times to accommodate individual member needs.
- OHC sent three ECCs to the local Disability Office for training on best care practices 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 determinants 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 standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

B. Cultural Competency Findings

- OHC hosts annual cultural competency training at each site during the months of June and July. Attendance at the two-hour training is mandatory with make-up sessions provided as needed.
- OHC screens for cultural preferences and collects information regarding race, ethnicity and language preferences for all members during the initial member intake visit. There was limited evidence, however, that this information was meaningfully incorporated into the member's plan of care as evidenced by the member files reviewed.
- OHC has identified "stereotyping" as a training area for future iterations of cultural competency staff training.

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

- OHC developed a comprehensive list of community resources that includes over 23 organizations that provide housing, mental health and addiction, crisis, transportation, literacy, food assistance, senior, and HIV/AID services, as well as resources for immigrants. OHC also utilizes Connecticut 2-1-1 for broad linkages to local services and specifically trains ECCs on use of the 2-1-1 website to find specific member resources.
- PCMH+ ECCs assess members' social determinants of health and are responsible for linking them to community resources as needed. The PCMH+ ECCs document linkages and referrals in progress notes, and utilize a Social Checklist form to identify member needs such as housing, food, childcare and immigration status.
- As noted in the physical health-behavioral health integration section, the ECCs share key needs of PCMH+ members during bi-weekly huddles. During these meetings, the care coordinators identify potential community partners and ways to establish formal partnerships with community organizations.
- ECCs have developed relationships with community partners through attendance at local community collaborative 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 and two DSS representatives who reviewed a total of 20 member files.

B. Member File Review Findings

- There was evidence that ECCs are successful in helping members to coordinate a variety of needs (e.g., access to transportation and completion of forms). Communication with the member and follow through was clearly documented in the member record.
- There was limited evidence of consistent practices for developing member plans of care. BH team members do utilize a multidisciplinary team plan which is comprehensive in nature, but it is not used consistently for members with BH conditions.
- There was limited evidence of universal BH screening in member files.
- OHC collects information about member language, religious preferences, racial and ethnic identities. Since there is no standardized care plan utilized by OHC, there was limited evidence demonstrating how cultural needs are incorporated into the care plan.
- OHC is still developing methods to educate members about Wellness Recovery Action Plans and how to support them through the Wellness Recovery Action Plan development process.
- There was limited evidence of consistently asking members if they have 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

OHC arranged two interviews with PCMH+ assigned members by phone.

- Both members were receiving PCMH+ enhanced care coordination interventions.
- Overall, the members were pleased with their providers. Neither indicated experiencing difficulty receiving medical care. One member even said he was "seeing every kind of doctor that's out there" and had no problem accessing medical care.
- The members were able to easily connect with their ECC by phone when needed.
- Neither member was familiar with the process to file a complaint, however, both members said they had never had a reason to file a complaint. One of the members said if she needed to file a complaint, she would find a way to do so. Both members said that if they did not agree with a decision made by their provider, they had no problem discussing this disagreement with their providers, and believed the provider would be open to hearing their concerns.
- In regard to programs that might require linkages to the community, one of the members reported working with his ECC to find a resource to assist him and his wife with housework and shopping needs.

APPENDIX A

OPTIMUS HEALTH CARE
RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	There has been limited member representation/ongoing participation in the Performance Improvement Committee meetings. OHC's May and June PCMH+ Monthly reports indicated there were no PCMH+ members in attendance.	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the Performance Improvement Committee meetings such that OHC demonstrates compliance with the "substantial representation" requirement within PCMH+.
	ECC member penetration rates are low for the 16,294 assigned PCMH+ membership. The PE reports the following monthly care coordination contacts: April 2017: 27 contacts; May 2017: 72 contacts; June 2017: 137 contacts; July 2017: 272 contacts.	Evaluate current PCMH+ care coordination member penetration rate, and develop a process to increase the number of PCMH+ members engaged in care coordination activities.
Physical Health-Behavioral Health Integration	BH screenings are not consistently documented. OHC is in process of identifying appropriate screening tools for use with adolescent and pediatric populations.	Ensure BH screenings and follow up for positive screens are clearly documented. Identify and implement BH screens appropriate for adolescent and pediatric populations.
Children and Youth with Special Healthcare Needs	There is currently not a formal process to identify Children and Youth with Special Health Care Needs or to obtain IEPs and 504 plans.	Develop a process to identify Children and Youth with Special Health Care Needs and to collect school information, including IEPs and 504 plans where applicable for incorporation into the member's plan of care.
Member File Reviews	There is limited evidence of consistent practices for developing member plans of care.	Consider development of a plan of care that can be used by both BH and PH PCMH+ staff to promote communication of member's needs across the treatment team.
	There is limited evidence of universal BH screening.	Formalize procedures to promote universal BH screening for PCMH+ members.
	There was limited evidence demonstrating how cultural needs are incorporated into the care plan.	Formalize procedures to collect members' cultural needs and preferences and incorporate them into the care plan.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Member File Reviews	The PE is still developing methods to educate members about WRAP and support them through the WRAP development process.	Formalize procedures to provide education to members about WRAP and the process to develop them.
	There is limited evidence of consistently asking members if they have a psychiatric advance directive.	Formalize procedures to assess members about the presence of a psychiatric advance directive and methods to store them in the member file.

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