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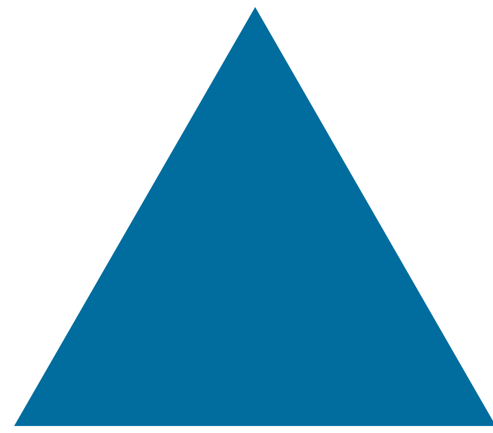
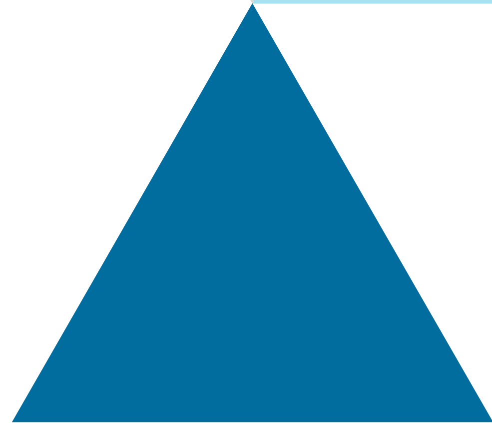
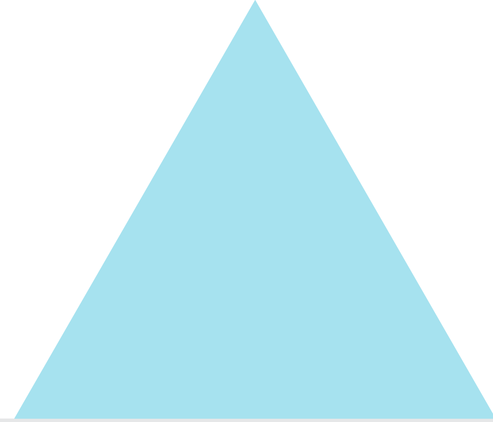


2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF SOUTHWEST COMMUNITY HEALTH CENTER

AUGUST 8, 2017





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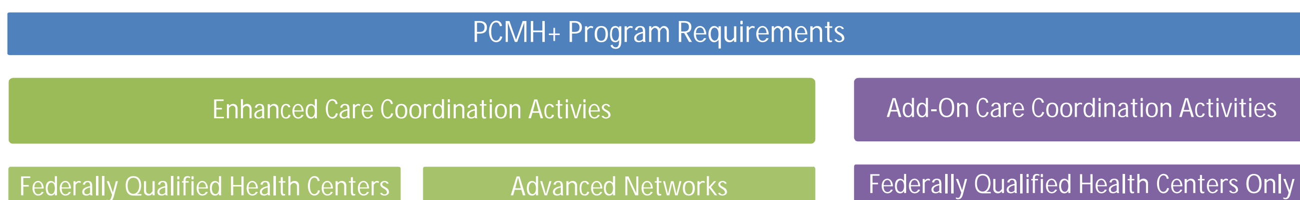
1 INTRODUCTION

The Person-Centered Medical Home Plus (PCMH+) program is part of the Connecticut Department of Social Services' (DSS) investment in value-based purchasing 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 Southwest Community Health Center (SWCHC) 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 PEs interdisciplinary team(s) and development of wellness recovery action plans for members with BH conditions. The following table provides a summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are in Section 3.

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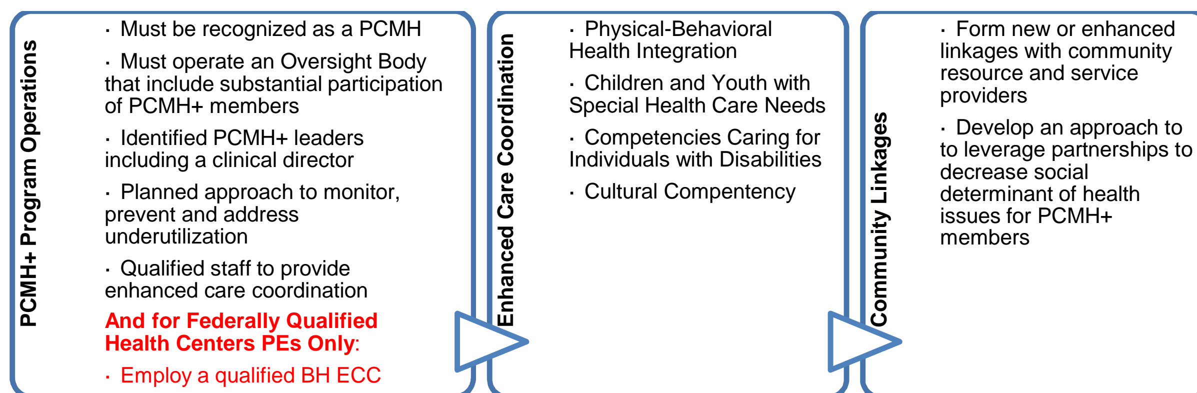
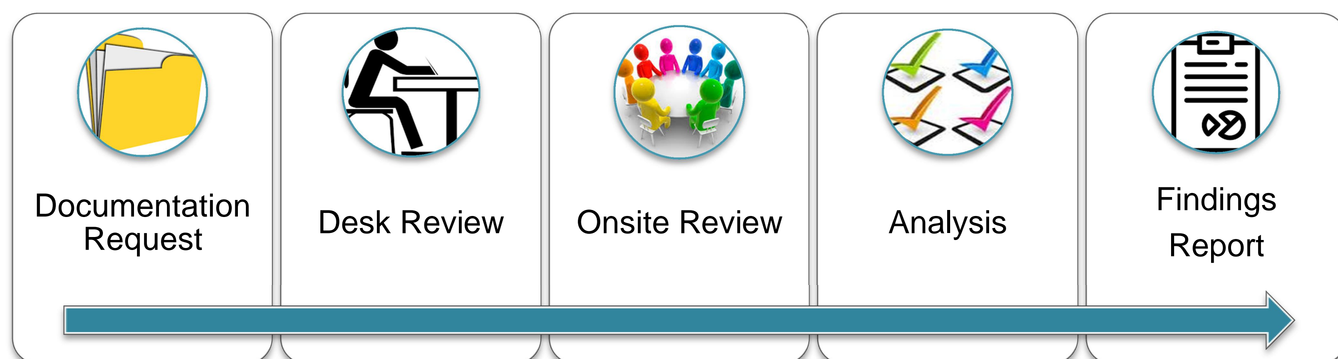


REVIEW METHODOLOGY

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



DOCUMENT REQUEST — JUNE 2017

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

DESK REVIEW — JULY 2017

Mercer received information electronically and reviewed all documents submitted to evaluate the PE's compliance with PCMH+ program requirements as detailed within the PCMH+ Request for Information. Areas where Mercer could not determine that the process or procedure was fully compliant with PCMH+ program standards were noted for follow-up discussion during the onsite interviews.

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ONSITE REVIEW — AUGUST 2017

The onsite review for SWCHC took place on August 8, 2017, at the offices located in Bridgeport, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff and appropriate SWCHC 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 SWCHC staff:

- Kathy Yacavone — President/Chief Executive Officer (CEO)
- Dr. Dara Richards — Chief Medical Officer (CMO)
- Nancy Wiltse — Chief BH Officer
- Dean Lederfeind — BH Clinical Services Director
- Carla Wright BS — BH ECC
- Yadiris Romero MS — 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

SWCHC PCMH+ PROGRAM OVERVIEW

SWCHC is a federally qualified health center serving Bridgeport that provides an array of primary care and specialist care including: community pediatrics, OB/GYN, internal medicine, HIV/AIDS, dental, BH, and a substance abuse treatment program that includes outpatient and evening groups. Additional services include community outreach, health education/disease prevention programs and entitlement enrollment services. SWCHC operates five neighborhood service delivery sites, six homeless clinic sites, seven school-based health center sites and one Women, Infant and Children site jointly managed with the federally qualified health center, Optimus Health Care.

Under PCMH+, SWCHC provides enhanced care coordination activities to 7,801 PCMH+ members (68% adults and 32% children). Staffing for PCMH+ includes four full-time ECCs, who are 100% dedicated to the PCMH+ program. All ECCs are cross-trained; two of the ECCs are assigned to members with medical conditions and two ECCs focus on members with BH conditions. The ECCs hold either a bachelor's or master's degree and have health care experience in BH or a medical setting. The President/CEO is the key leader of the PCMH+ program. The CMO reports to the President/CEO and directly oversees the PCMH+ program. The CMO is involved in the education and training of the ECC staff. The lead ECC reports directly to the CMO on all aspects of the PCMH+ program.

The ECCs are a part of an "integrated" care team model which works together in order to enhance the member's capacity to improve their health. SWCHC's monthly PCMH+ reporting submitted to DSS, notes zero care coordination contacts in April 2017, 57 care coordination contacts May 2017, 172 care coordination contacts in June 2017 and 202 contacts in July 2017.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	SWCHC utilizes Community Health Network of Connecticut (CHNCT) provider profile reports and CHNCT Care Analyzer information to assess health risks of the population and identify cohorts of members who are in need of targeted, enhanced care coordination services. The information is disseminated to clinical staff through provider, department, and committee meetings, as well as individual provider and manager communication so that all staff can promptly follow up to close gaps in care.
Physical Health-Behavioral Health Integration	SWCHC's service array includes a substance abuse treatment program that includes medication assisted therapy, outpatient substance abuse services, evening groups and BH services within their school-based health clinics.
Competencies Caring for Individuals with Disabilities	SWCHC screens all members for disabilities and conducts functional assessments of all members.

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REVIEW AREA	STRENGTH
Community Linkages	SWCHC maintains a robust list of community resources that comprehensively addresses the needs of individuals served by SWCHC.
	SWCHC is a member of a coalition of healthcare providers in the Greater Bridgeport Area called the Primary Care Action Group. The Primary Care Action Group evaluates the current health status of the community and identifies and prioritizes areas for further collaboration and coordination across organizations, institutions and community groups.
Member File Reviews	All care team members have access to the NextGen® electronic health record and may make referrals across disciplines.
	SWCHC utilizes a Care Management Plan or Patient Plan to document member needs, social determinants of health, goals and referrals.
	SWCHC utilizes an Individualized Action Plan as the Wellness Recovery Action Plan. The Individualized Action Plan targets key recovery goals, is individualized, and is accessible to all treatment team providers through the electronic health 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 SWCHC 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	SWCHC has not completed the process of establishing a Community Advisory Board that includes substantial representation by PCMH+ members as well as one participating provider assigned to SWCHC.
	Enhanced care coordination member penetration rates were initially low, but are steadily improving. For the 7,801 assigned PCMH+ members, SWCHC reports the following monthly ECC contacts: April 2017: zero contacts; May 2017: 57 contacts; June 2017: 172 contacts; July 2017: 202 contacts.
	SWCHC's quality improvement plan does not include annual goals, mention of the PCMH+ program, identification of the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.
Physical Health-Behavioral Health Integration	Individualized Wellness Recovery Action Plan implementation was limited as of the time of the review and members were not being provided their recovery plan when completed.
	SWCHC is building processes to identify transition age youth and will be leveraging their existing plan of care to build transition plans that address linkages to adult services beyond medical services within SWCHC.

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REVIEW AREA	OPPORTUNITY
Member File Reviews	There was inconsistent evidence of asking for and/or documenting if a member has a psychiatric advance directive.
	There was inconsistent evidence of collecting cultural needs and preferences.
	There was inconsistent evidence of universal BH screening.

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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 used to assess health risks of the population and identify cohorts of members who are in need of targeted, enhanced care coordination services. The CMO, Quality Improvement/Quality Assurance Director and the Lead ECC are responsible for downloading the reports and sharing information monthly with clinical staff through provider, department, and committee meetings, as well as individual provider and manager communication so that all staff can promptly follow up to close gaps in care.
- SWCHC is in the process of establishing a Community Advisory Board. This board will be a member-led and staff supported committee that meets quarterly. SWCHC is hoping to hold their first meeting in August 2017. SWCHC discussed ideas for gaining PCMH+ member participation in the Community Advisory Board. Offering food, arranging transportation, providing agendas and meeting materials ahead of meetings were examples of ways SWCHC could remove barriers for member attendance.
- SWCHC has a quality improvement plan which is dated May 26, 2016, and includes quality improvement activities and gives an overview of the governance body and describes how the various subcommittees support the larger body. The quality improvement plan does not include the annual goals, the PCMH+ program, the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated and contributes to SWCHC's

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quality goals. SWCHC was encouraged to include the PCMH+ program and evaluation efforts in future iterations of the quality plan.

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.
- SWCHC's submission indicated underservice and/or denial of care is prohibited and contrary to their mission and HRSA Federal Section 330 requirements and they provided a summary of their process to monitor for underservice.

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

- SWCHC has a process to conduct universal BH screenings of members aged 12 years and up using the PHQ-2/9. For members scoring positive for a possible BH condition, they conduct a warm transfer to their BH team with immediate evaluation or individual and/or group counseling sessions. However, there was inconsistent evidence of universal screening noted in the files reviewed.
- BH screening and evaluation includes other tools such as the 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.),

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CAGE (Substance Abuse screening tool) and CRAFFT (screening tool for used to screen adolescents for high risk alcohol and other drug use disorders).

- SWCHC reported 1,293 PCMH+ members screened for BH conditions from April 2017- June 2017.
- SWCHC's service array includes a substance abuse treatment program that includes medication assisted therapy, outpatient substance abuse services, evening groups and BH services within their school based health clinics.
- SWCHC has developed their own wellness and recovery planning tool they term "Individualized Action Plan" that includes key elements of a recovery planning tool. Implementation was limited at the time of the review and members were not being provided their recovery plan when completed. Technical assistance was provided around the value of members "owning" their recovery plan and having the option to update as need and to share its elements with treating providers, resource agencies, friends and other supports as they desire.
- SWCHC is building processes to identify transition age youth and will be leveraging their existing plan of care to build transition plans that address linkages to adult services beyond medical services within SWCHC.

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

- Prior to PCMH+, SWCHC had typically identified Children and Youth with Special Health Care Needs primarily by member diagnosis such as members with cerebral palsy or Down's syndrome. This has been expanded to include screening for special needs using a tool they adapted from publically available tools that also identifies durable medical equipment and other home needs and flags these members within their electronic health record, NextGen®.
- SWCHC has implemented a new process to collect IEPs and 504 plans. Prior to PCMH+, they relied on parents to bring in these documents. The new process takes an active approach with parents and includes building stronger relationships with schools by leveraging SWCHC staff located within their school based health centers to drive improved communication with schools.

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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

- SWCHC has a process to screen members for disabilities and make special accommodations for members such as adjustable exam tables and extended appointment times. Members needing adaptive equipment or adjusted appointment times are notated with the electronic health record so that staff scheduling appointments can make necessary adjustments prior to the appointment.
- All members are screened using functional assessments that evaluate for Activities of Daily Living and Instrumental Activities of Daily Living needs. There is an additional template for staff to document adaptive equipment needs for members with identified functional limitations to ensure home needs are addressed.

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

- SWCHC holds staff training which includes cultural competency, disability and Children and Youth with Special Health Care Needs topics at the time of hire and annually thereafter. The cultural competency training is geared toward using what staff learn regarding culture to assist members and to consider culture as they build the plan of care.
- SWCHC has staff that speak various languages consistent with the population they serve including: Haitian/Creole and French, Korean, Chinese, Russian and Romanian.

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- SWCHC screens for cultural preferences and collects information regarding race, ethnicity, literacy, learning needs and language preferences for all members during the initial member intake. This information is documented in the electronic health record care management template.

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

- SWCHC screens members for social determinant and resource gaps with information collected within their EHR.
- SWCHC has developed a comprehensive list of community resources that includes partnerships with organizations that provide services such as: housing, utility bill assistance, food assistance, transportation, mental health and addiction, HIV/AID services, spiritual/ministry, and senior services. Additional relationships include: soup kitchens, homeless shelters providing faith-based support programs, child-serving organizations, justice-related groups and Connecticut 2-1-1, which provides broad information on local services
- SWCHC is a member of a coalition of healthcare providers in the Greater Bridgeport Area called the Primary Care Action Group. The Primary Care Action Group evaluates the current health status of the community and identifies and prioritizes areas for further collaboration and coordination across organizations, institutions and community groups.

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.

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- 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

- SWCHC utilizes NextGen® as their electronic health record. All care team members have access to the electronic health record, and may make referrals across disciplines.
- SWCHC utilizes a Care Management Plan or Patient Plan to document member needs, goals and referrals. The care management plans identified unmet social determinants of health (if applicable) and steps taken by the ECC to assist with addressing needs.
- SWCHC is using an Individualized Action Plan as the Wellness Recovery Action Plan. The Individualized Action Plan targets key recovery goals and is individualized per member. The plan is accessible through the electronic health record.
- Cultural preferences, such as language, religion, and how the member identifies their race and ethnicity were evident, but not present in all files reviewed.

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- There was limited evidence of consistently asking for and/or documenting if a member has a psychiatric advance directive on file. For some members, the electronic health record clearly indicates if there is none (providers may click "none").
- There was inconsistent documentation supporting annual universal BH screenings.

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

SWCHC arranged two interviews with PCMH+ assigned members; one in person and the other by phone.

- The members knew who their ECCs were, and were able to easily connect with their ECC by phone when needed. Both members emphasized that they notice a difference in their care experience due to the ECC. The ECC assisted the members in arranging for concerns relating to respite, utility assistance and help with school choice. Both members stated that without access to the ECC, they would not know about available community services or how to access them.
- Both members showed interest in joining the consumer advisory board after their ECC informed them of the board's existence. The ECC was in process of providing information for the members.
- Neither member reported any issues accessing medical care. One member sees a specialist every six months and the other member cares for her grandson with chronic health concerns.
- Neither member was familiar with the process to file a complaint but stated they had never had any complaints.

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APPENDIX A

SOUTHWEST COMMUNITY HEALTH CENTER RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	SWCHC has not completed the process of establishing a Community Advisory Board that includes substantial representation by PCMH+ members as well as one participating provider assigned to SWCHC.	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the Community Advisory Board meetings such that SWCHC demonstrates compliance with the "substantial representation" requirement within PCMH+.
	Enhanced care coordination member penetration rates are low, but steadily improving, for the 7,801 assigned PCMH+ membership. SWCHC reports the following monthly care coordination contacts: April 2017: 0 contacts; May 2017: 57 contacts; June 2017: 172 contacts; July 2017: 202 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.
	SWCHC's quality improvement plan does not include annual goals, mention of the PCMH+ program, identification of the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.	Update quality improvement plan to include the PCMH+ program, the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.
Physical Health-Behavioral Health Integration	Individualized Action Plan implementation was limited as of the time of the review and members were not being provided their recovery plan when completed.	Expand use of Individualized Action Plans and develop a process to ensure members are provided their Individualized Action Plans and opportunities to update as necessary.
	SWCHC is building processes to identify transition age youth and will be leveraging their existing plan of care to build transition plans that address linkages to adult services beyond medical services within SWCHC.	Finalize process to identify transition age youth and development of transition age youth plans of care that address transition needs.

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REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Member File Reviews	There was inconsistent evidence of asking for and/or documenting if a member has a psychiatric advance directive.	Develop processes to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record.
	There was inconsistent evidence of collecting cultural needs and preferences.	Develop procedures to consistently document cultural needs and preferences in the member record.
	There was inconsistent evidence of universal BH screening.	Develop procedures to promote universal BH screening for PCMH+ members.

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