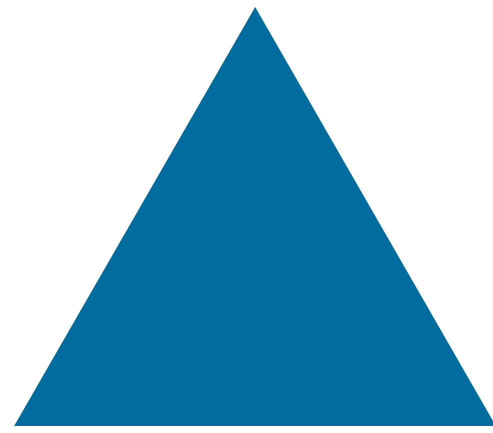
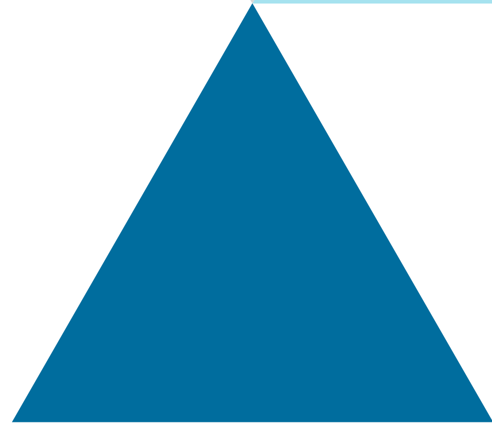
HEALTH WEALTH CAREER

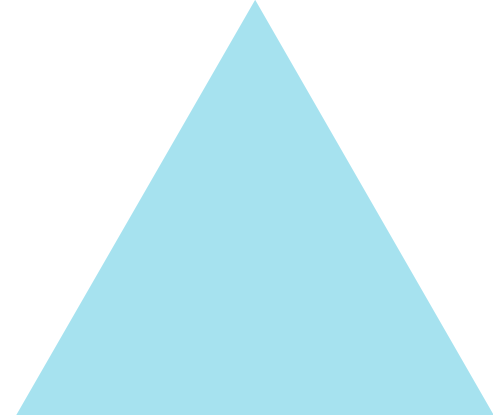


2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF VALUE CARE ALLIANCE

AUGUST 9, 2017





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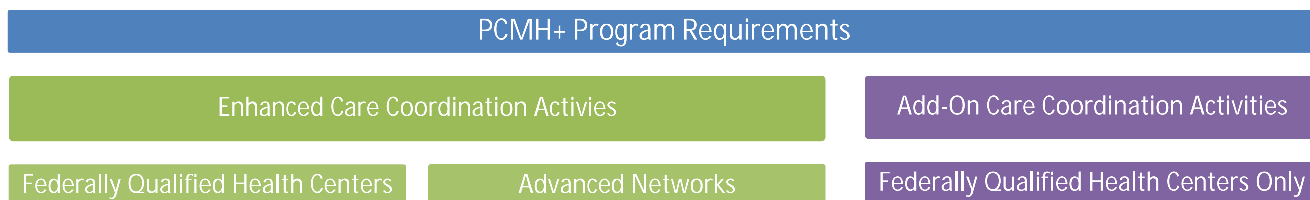
INTRODUCTION

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 that are federally qualified health centers 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 PE's interdisciplinary team(s) and development of Wellness Recovery Action Plans for members with BH conditions. Since Value Care Alliance (VCA) is an Advanced Network, PCMH+ federally qualified health center "Add-on Care Coordination" requirements were not evaluated and are not noted in this report.

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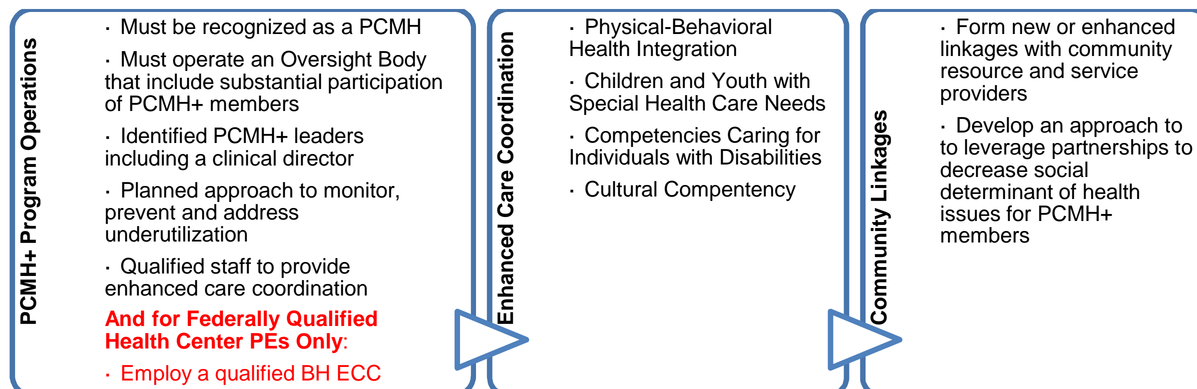
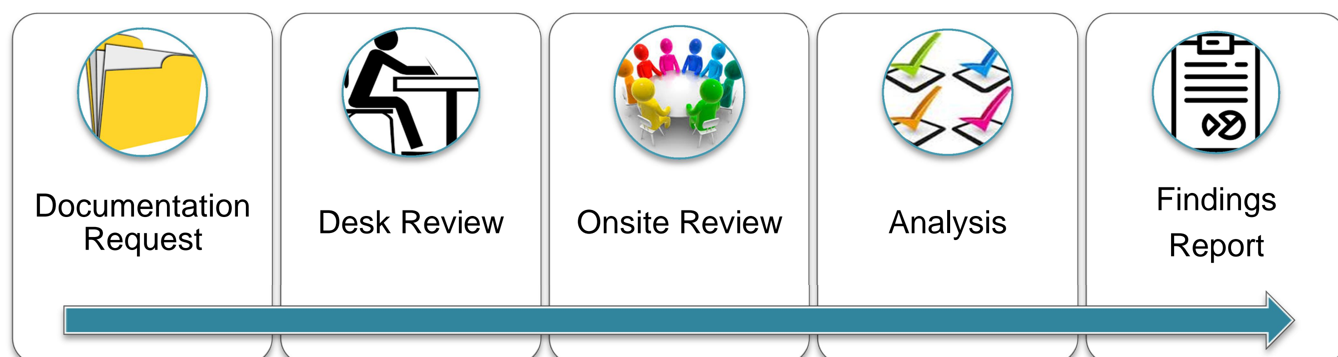
The following table provides a summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are in Section 3.



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).

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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 VCA took place on August 9, 2017, at the offices located at the Griffin Hospital location in Derby, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff and appropriate VCA 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 VCA and St. Vincent's Health Partners staff:

- Jeanne O'Brien — CEO, VCA
- Kirstin Anderson — Chief Medical Officer, VCA
- Michael Hunt — CEO/President St. Vincent's Health Partners
- Georgia Pelletier — Director of Population Health, VCA
- Valayshia Brookins — BH Social Worker
- Charles Kuchenbrod — Intern, VCA

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

VCA PCMH+ PROGRAM OVERVIEW

VCA is collaboration of Connecticut health care systems, including hospitals and organized physician groups. VCA was formed in 2015 and includes the following participants:

- St. Vincent's Medical Center
- Griffin Hospital
- Western Connecticut Health Network
- Middlesex Hospital

As participants in the advanced network, these partners provide enhanced care coordination activities to 16,714 PCMH+ members, including activities provided via primary care practices currently participating in DSS' PCMH program.

For the PCMH+ program, VCA staffs three ECCs/Community Health Workers, who are dedicated 100% to the PCMH+ program. One of VCA's ECCs has a BH background; a best practice that exceeds the Advanced Network requirements in the PCMH+ program.

VCA is governed by a Board of Directors and supporting committees. The Board of Directors has delegated to the Clinical Quality and Performance Committee responsibility for performing quality program oversight and assuring VCA meets its quality program's goals and objectives. The subcommittees of the Clinical Quality and Performance Committee include the Care Coordination Subcommittee, the Clinical Guidelines Subcommittee, Pharmacy Subcommittee, Practice Management Subcommittee, the Emergency Department and Post-Acute Utilization Subcommittee and the Palliative Care Committee. Coordination between these committees occurs as needed to ensure consistent quality improvement.

As of the July PCMH+ Monthly Reporting, VCA reports the following monthly care coordination contacts: 200 care coordination contacts in April 2017: 200 contacts; May 2017: 107 contacts; June 2017: 107 contacts; July 2017 141 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	VCA has created proprietary "Gaps in Care Reporting" to drive closure of health care service gaps within the PCMH+ membership (and broader served populations). In addition, VCA has developed quality measure reports that allow VCA to track PCMH+ quality measure performance across many of the PCMH+ program quality measures.
Program Operations	VCA has a robust quality program which includes annual goals, gives an overview of the governance body and describes how the various subcommittees support the larger body.

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REVIEW AREA	STRENGTH
Physical Health-Behavioral Health Integration	ECCs demonstrated a clear understanding of culture beyond language and interpretation requirements. They provided examples of how unique cultural needs such as homelessness can impact the health outcomes of members.
	Positive substance use screens generally prompt a referral to an outside Intensive Outpatient Program for a comprehensive substance use disorder assessment.
Community Linkages	VCA maintains a comprehensive list of community resources that includes over 60 organizations. The list addresses a variety of resource needs for individuals served by VCA.
	VCA conducts a weekly Community Care Team meeting to review member cases related to resource needs. The ECCs attend these meetings alongside interdisciplinary team members such as BH staff members, first responders, emergency room staff and other community agency representatives such as shelter staff.
Member File Reviews	ECCs complete assessments to identify social determinants of health needs, including housing, employment, education, transportation, child care, school, community involvement, juvenile justice and other legal 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 VCA 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	Based on the VCA's PCMH+ Provider Monthly Report and desk review information, it's not clear if all outstanding practices will achieve required PCMH recognition in the required 18-month timeframe.
	There has been limited member representation/ongoing participation in the oversight body meetings. VCA's July PCMH+ Monthly report indicated one PCMH+ member in attendance.
	In VCA's Quality Program Description, the PCMH+ program is referred to as the PCMH+/CCIP program. CCIP, or the Community and Clinical Integration Program, is a separate initiative under the Connecticut State Innovation Model that provides technical assistance to participants within that program for goals that are unique to that program, and while complimentary to PCMH+, is a separate program with unique goals and requirements.

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REVIEW AREA	OPPORTUNITY
Program Operations	Enhanced care coordination member penetration rates are low for the 16,714 assigned PCMH+ membership.
	During the onsite review, VCA indicated that they utilize three Community Health Workers for enhanced care coordination for the PCMH+ program. However, the monthly report states that VCA utilizes four clinical ECCs for PCMH+ care coordination.
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.
Physical Health-Behavioral Health Integration	VCA has not adopted a standardized definition for transition age youth and as such, these members are not identified for transition planning as required within PCMH+ standards.
Children and Youth with Special Health Care Needs	VCA indicated they are currently unable to identify Children and Youth with Special Health Care Needs.
Competencies Caring for Members with Disabilities	Annual staff training, including the current cultural competency training, does not address the needs of individual with disabilities.
Cultural Competency	Not all team members can access cultural assessments completed by the PCMH+ ECCs in the Symphony (electronic health record).
Community Linkages	Not all team members can access social determinant and community resource needs assessments completed by the PCMH+ ECCs in the Symphony (electronic health record).
Member File Reviews	PCMH+ ECCs and the VCA’s clinical ECCs (who provide clinical support separate from PCMH+) develop separate care plans.
	There was inconsistent screening for social determinants of health. However, for those members who are screened, there is clear evidence of follow up by the ECCs to ensure the members’ needs are met.
	There was inconsistent evidence that staff ask members if they have developed a Wellness Recovery Action Plan or psychiatric advance directive. Some member charts provided evidence of the practice, but others did not.

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DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

A. PCMH+ Program Operations Requirements

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

- Having an oversight body, supporting PCMH+ which includes substantial representation by PCMH+ members.
- Having a senior leader and a clinical director providing oversight for the PCMH+ program.
- Having sufficient care coordination staff to provide the enhanced care coordination required activities to provide timely care coordination to PCMH+ assigned members.
- Having a quality program, including annual goals and annual quality work plan that includes specific PCMH+ program goals and activities.
- Evaluating and utilizing the results of provider profile reports to improve the quality of care.
- Completing and submitting the PCMH+ monthly report based on specifications provided by DSS.
- PCMH+ Advanced Network PEs are required to have all practice sites recognized as PCMH practices within 18 months of the start of the program.

B. PCMH+ Program Operations Findings

- VCA reports that all practices at Griffin Hospital are National Committee for Quality Assurance PCMH recognized; three practices at Middlesex Hospital are working toward National Committee for Quality Assurance PCMH recognition; two practices at Western Connecticut Health Network are working on National Committee for Quality Assurance PCMH recognition; and two practices at VCA are not yet National Committee for Quality Assurance PCMH recognized. It was not clear, based on the most recent PCMH+ Provider Monthly Report, when the practices that are pending PCMH+ recognition are scheduled to achieve recognition. PCMH+ Advanced Network PEs are required to have all practice sites recognized as PCMH practices within 18 months of the start of the program. It is unclear if this requirement will be met.
- Provider profile reports and Care Analyzer information provided by the HUSKY Administrative Services Organization-Community Heath Network of Connecticut (CHNCT), is used to supplement VCA generated data and is incorporated into the VCA's Gaps in Care Report. VCA distributes the Gaps in Care Report monthly to medical directors, Chief Medical Officers and other designated members at each hospital to focus on closing health care gaps with PCMH+ members.

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- VCA's oversight body meeting was held in June and one PCMH+ member attended. VCA shared frustration in the lack of success in recruiting PCMH+ members for attendance in the meeting despite significant efforts to recruit, educate and remove barriers for member's attendance including arranging transportation, offering food and child care and having ECCs serve in a support role for members who agreed to attend. Technical assistance was provided during the onsite that included options to attract and recruit PCMH+ members including: reaching out to current PCMH+ care coordination members, building trusted relationships between the ECC and the member, educating members on the advisory board function and continuing efforts to reduce barriers to attendance.
- VCA has a robust quality program which includes annual goals, gives an overview of the governance body and describes how the various subcommittees support the larger body. The quality program includes quality performance standards as well as initiatives related to PCMH+ quality reporting. However, within the Quality Program Description, the PCMH+ program is referred to as the PCMH+/CCIP program. CCIP is a separate initiative under the Connecticut State Innovations Model that provides technical assistance to participants within that program for goals that are unique to that program and are separate from PCMH+ goals and requirements. VCA is encouraged to define these programs separately and note the differing requirements and standards within the Quality Program Description.
- VCA indicates they leveraged CCIP funding to support the hiring of the PCMH+ ECC staff. While this is not prohibited, it could cause potential confusion between the programs which have different requirements and standards. It will be important for VCA to clearly differentiate between the programs to ensure PCMH+ requirements are met.
- VCA utilizes three ECCs, one of which has a BH background for care coordination activities with their PCMH+ members. Having an ECC with BH experience is a best practice that exceeds the Advanced Network requirements in the PCMH+ program. VCA has policies and procedures in place describing the educational and experience requirements of these roles.
- During the onsite review, VCA indicated that they utilize three Community Health Workers for enhanced care coordination for the PCMH+ program. However, the monthly report states that VCA utilizes four clinical ECCs for PCMH+ care coordination. VCA needs to clarify which staff are designated to provide PCMH+ enhanced care coordination to PCMH+ assigned members.
- The Director of Population Health, who is a registered nurse, oversees the PCMH+ ECCs and meets with the teams weekly to discuss care coordination of the PCMH+ members.
- As of the July PCMH+ Monthly Reporting, VCA reports the following monthly care coordination contacts: 200 care coordination contacts in April 2017: 200 contacts; May 2017: 107 contacts; June 2017: 107 contacts; July 2017 141 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:

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- 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.
- VCA's document submission indicated they are leveraging the Mercer developed PCMH+ Underservice Utilization Monitoring Strategy.
- VCA shared that the PCMH+ staff meet on a weekly basis, and the CEO has shared with staff that they are here to assist members with their health and resource needs and that underservice will not be tolerated.

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

- VCA has expanded BH screenings beyond depression and currently uses PHQ-2/ PHQ-9-depression screen, GAD 7-anxiety screen, CRAAFT-SUD screen), and PCL-C- trauma-PTSD. Positive substance use screens generally prompt a referral to an outside Intensive Outpatient Program for a comprehensive substance use disorder assessment.
- PCMH+ ECCs shared they are prompted to ask if members have recovery plans, like a Wellness Recovery Action Plan, and psychiatric advanced directives. In addition, they report educating members on wellness recovery tools and psychiatric advanced directives and plan to assist members with referrals if desired by the member.
- VCA has not adopted a standardized definition for transition age youth and as such, these members are not identified for transition planning as required within PCMH+ standards.

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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

- VCA indicated they are currently unable to identify Children and Youth with Special Health Care Needs with limited plans to do so in the future. As such the requirements for this element were not met.

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

- VCA reports that members who need accommodations are flagged within their electronic health record systems. For members who need longer appointment times, this is accommodated with appointment options that expand to 30 or 45 minutes in length. VCA also has adaptive equipment, including adaptive exam tables.
- VCA shared they currently have adaptive access for dental services and mammography for members with disabilities.
- Staff training on disability competency is not currently offered.

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

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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

- VCA utilizes HealthStream® to conduct annual cultural competency training for all staff. HealthStream® is an online training program which allows VCA to track training completion.
- As already noted, Staff training on disability competency is not currently offered.
- Each hospital under VCA has a mission statement which includes a commitment to cultural competency. VCA did not provide evidence regarding how VCA implements CLAS standards at governance, leadership and workforce levels.
- VCA collects race, ethnicity and language preferences for all members during the initial member intake, however there was limited evidence demonstrating that cultural needs and preferences are incorporated into a member's care plan.
- PCMH+ ECCs complete a cultural assessment questionnaire which is uploaded into Symphony – one of VCA's electronic health record systems. Currently, only the ECCs have access to Symphony. ECCs share information either verbally or via secure email with other treatment team members. VCA does not have processes in place to allow other team members to access the ECC cultural assessment questionnaire when completed for a PCMH+ member.

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

- VCA has developed a comprehensive list of community resources maintained by each individual office. The list includes over 60 organizations that provide services such as housing, mental health and addiction, crisis and emergency, transportation, domestic violence, food assistance, spiritual/ministry, linkages to law enforcement, and specialty services for individuals living with HIV/AIDs and individuals with disabilities. VCA also utilizes Connecticut 2-1-1 for broad linkages to local services.

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- Each hospital in the advanced network hosts a Community Care Team which offers a weekly opportunity for team members to review member cases. ECCs attend all of these meetings alongside interdisciplinary team members such as BH staff, first responders, emergency room staff and other community agency representatives such as shelter staff. Members must sign a consent form in order for their case to be reviewed during the Community Care Team.
- ECCs assess members for social determinants of health and are responsible for linking them to community resources as needed. ECCs document linkages and referrals in progress notes; however, other team members do not have a formal way to review these notes. The ECCs meet weekly with the clinical team and share information verbally or via secure email.

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.

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- 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

- VCA's ECCs complete a resource focused assessment for a member which includes elements such as housing, employment, education, transportation, child care, school, community involvement, juvenile justice and other legal needs. The assessment is housed in Symphony (a clinical documentation platform) and can be printed out for members once complete.
- For members with BH conditions, the BH ECC demonstrates strong follow up with the member and coordinates with the team to ensure the member's needs are met.
- Documentation of ECC progress notes are in a separate electronic health record. Progress notes are not easily accessible for team members outside of the care coordination team, but the team indicates they communicate verbally and via email to relay information about members.
- Screening members for BH conditions was evident in the files reviewed. Members who screened positive were either already connected to or were referred to BH following the screening.
- There was inconsistent screening for social determinants of health. However, for those members who are screened, there is clear evidence of follow up by the ECCs to ensure the member's needs are met.
- There was inconsistent evidence that staff ask members if they have developed a Wellness Recovery Action Plan or psychiatric advance directive. Some member charts provided evidence of the practice, but others did not.

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.

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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

VCA secured an interview by phone with one PCMH+ assigned member.

- The interviewed member did not appear to have been actively receiving PCMH+ enhanced care coordination interventions, which was confirmed by VCA.
- Overall, the member was very pleased with his provider. He related that he does not have issues receiving medical care.
- The member was unaware of having an ECC but recounted that the practice responds quickly to phone calls.
- The member was unfamiliar of the process to file a complaint but reiterated that he had never had any complaints. The member said he makes his wishes known and is "very clear" and has never had a problem accessing care.
- The member maintained that he did not have any need for programs that might require linkages to the community, such as housing or food services. The member said that if he did need a community resource, he was confident that his provider would assist him in attaining those resources.

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APPENDIX A

VALUE CARE ALLIANCE RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	Based on the most recent PCMH+ Provider Monthly Report, it is not clear if all outstanding practices will achieve required PCMH recognition in the required 18-month timeframe.	Provide an update to DSS on the status of PCMH recognition for sites pending recognition with target dates.
	There has been limited member representation/ongoing participation in the oversight body meetings. VCA's July PCMH+ Monthly report indicated one PCMH+ member in attendance.	Develop a plan to recruit and retain sufficient PCMH+ members to participate on the Member Advisory Board such that VCA demonstrates compliance with the "substantial representation" requirement within PCMH+.
	In VCA's Quality Program Description, the PCMH+ program is referred to as the PCMH+/CCIP program. CCIP is a separate initiative under the Connecticut State Innovations Model that provides technical assistance to participants within that program for goals that are unique to that program and while complimentary to PCMH+, is a separate program with unique goals and requirements.	Define PCMH+ and CCIP programs separately within the Quality Program Description and other VCA documentation.
	Enhanced care coordination member penetration rates are low for the 16,714 assigned PCMH+ membership. VCA reports the following monthly care coordination contacts: April 2017: 200 contacts; May 2017: 107 contacts; June 2017: 107 contacts; July 2017: 141 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.
	During the onsite review, VCA indicated that they utilize three Community Health Workers for enhanced care coordination for the PCMH+ program. However, the monthly report states that VCA utilizes four clinical ECCs for PCMH+ care coordination.	Specify via organization charts, PCMH+ Monthly Reports and job descriptions which staff are specifically providing PCMH+ enhanced care coordination to PCMH+ assigned members.

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REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	VCA indicates they leveraged CCIP funding to support the hiring of the PCMH+ care coordination staff. While this is not prohibited, it could cause potential confusion between the programs which have different requirements and standards.	Establish and communicate clear differentiation between the PCMH+ and CCIP programs to ensure PCMH+ requirements are met.
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.
Physical Health-Behavioral Health Integration	VCA has not adopted a standardized definition for transition age youth and as such, these members are not identified for transition planning as required within PCMH+ standards.	Develop a process to identify transition age youth to prompt for transition of care support
Children and Youth with Special Health Care Needs	VCA indicated they are currently unable to identify Children and Youth with Special Health Care Needs.	Develop a process to identify Children and Youth with Special Health Care Needs, provide advanced care planning and to collect school information including IEP and 504 plans when applicable.
Competencies Care for Members with Disabilities	Annual staff training, including the current cultural competency training, does not address the needs of individual with disabilities.	Train staff on the unique needs of members with disabilities.
Cultural Competency	Not all team members can access cultural assessments completed by the PCMH+ ECCs in the Symphony (electronic health record).	Develop a process to ensure all treating staff can access members' cultural preferences information.
Community Linkages	Not all team members can access social determinant and community resource needs assessments completed by the PCMH+ ECCs in the Symphony (electronic health record).	Develop a process to ensure all treating staff can access members' community linkage needs.
Member File Reviews	PCMH+ ECCs and VCA's clinical ECCs (who provide clinical support separate from PCMH+) develop separate care plans.	Consider development of a plan of care that can be used by both the PCMH+ ECCs and the clinical ECCs to promote communication of member's needs across the treatment team and reduce potential duplication of effort.

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REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Member File Reviews	There was inconsistent evidence of assessing Children and Youth with Special Health Care Needs for social determinants of health, school information or other unique needs of Children and Youth with Special Health Care Needs.	Formalize procedures to assess Children and Youth with Special Health Care Needs for social determinants of health, school information or other unique needs of Children and Youth with Special Health Care Needs and methods of documentation in the member's file.
	There was limited evidence of universal BH screenings.	Formalize procedures to promote universal BH screening for PCMH+ members.
	There was limited evidence that members were assessed for disabilities.	Formalize procedures to identify members with disabilities and their needs in the members' care plans.
	There was inconsistent screening for social determinants of health. However, for those members who are screened, there is clear evidence of follow up by the ECCs to ensure the members' needs are met.	Consider developing processes that ensure consistent screening for social determinants of health within the PCMH+ population.
	There was inconsistent evidence that staff ask members if they have developed a Wellness Recovery Action Plan or psychiatric advance directive. Some member charts provided evidence of the practice, but others did not.	Ensure that members with Wellness Recovery Action Plan and psychiatric advance directive have that information considered and incorporated into their plans of care were appropriate.

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