HEALTH WEALTH CAREER

PCMH+ WAVE 1 COMPLIANCE REVIEW FINDINGS WEBINAR

CT DSS PCMH+ PROGRAM

November 20, 2017

AGENDA

Compliance Review Purpose

Review Methodology

- Program Operations
- Monitoring for underservice
- Enhanced Care Coordination
- Community Linkages

Onsite Review Process

- Member Interviews
- Member File Reviews

Program Strengths and Opportunities

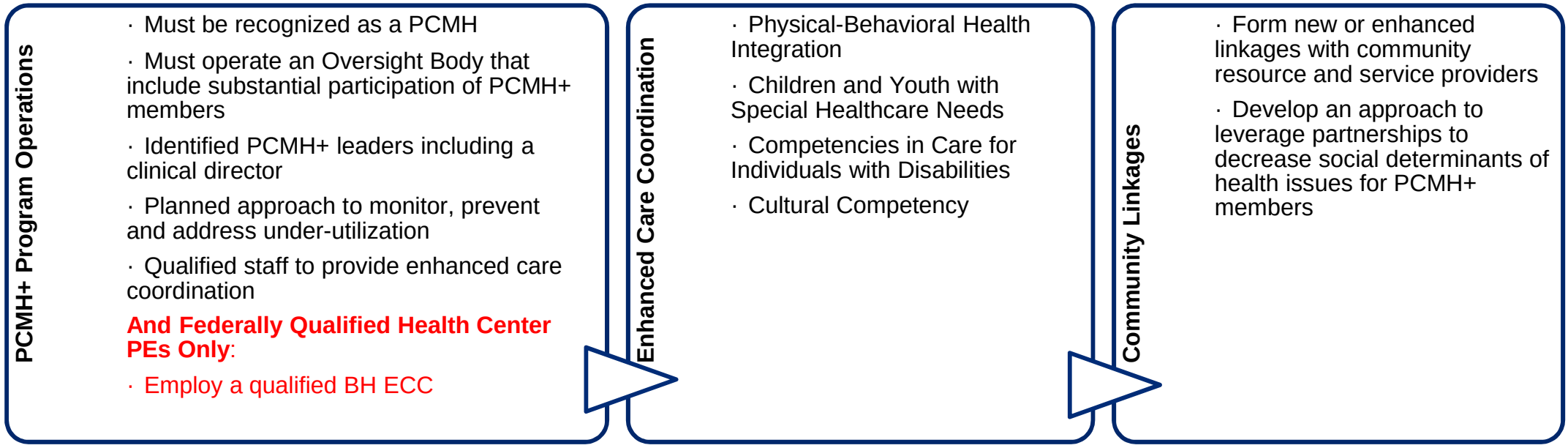
Q&A

PCMH+ COMPLIANCE REVIEWS
PURPOSE

- PCMH+ is part of DSS' investment in value based purchasing and care coordination
- PCMH+ builds on the DSS PCMH Program that currently includes 112 practices serving 47% of HUSKY members
- PCMH+ Wave 1 went live January 1, 2017
- Nine Participating Entities (7 FQHCs and 2 Advanced Networks) that must be recognized as NCQA PCMH or certified by The Joint Commission as a PCMH
- Providing Enhanced Care Coordination to 102,391 assigned Husky members (as of August 2017)
- Compliance Reviews are key element of DSS' Evaluation Tools for the PCMH+ Program

REVIEW METHODOLOGY

- Evaluation based on PCMH+ Program RFP Requirements



- June 2017 - Desk Review
  - PEs submitted documentation to demonstrate compliance with RFP requirements.
  - Documents were evaluated by DSS and Mercer teams. Gaps in information or areas where compliance could not be established were noted for follow-up during the onsite reviews.
- August 2017 - Onsite Reviews

ONSITE REVIEW PROCESS

- Onsite reviews were 6-8 hours in duration per PE
- Onsite process included:
  - Interviews with Participating Entity Leadership and PCMH+ program management staff
  - Discussed PCMH+ operations including follow-up on desk review open items
  - Interviewed PCMH+ Enhanced Care Coordinators and Behavioral Health Enhanced Care Coordinators (for FQHCs only)
  - Interviews with 2 PCMH+ members to evaluate member experience.
    - Most were face-to-face, but team did accommodate members who could not attend in person via phone
  - Mercer and DSS teams evaluated 20 PCMH+ Member files

PROGRAM STRENGTHS

AREA	STRENGTH
Program Administration	PCMH+ has stimulated PEs to build or refine internal member risk stratification reporting to identify their highest risk members.
	The PEs were open to recommendations and technical assistance provided by the review teams.
	Many PEs are using community health workers as their ECCs and BH ECCs which appears to be increasing the community health worker workforce.

PROGRAM STRENGTHS

AREA	STRENGTH
Physical Health-Behavioral Health Integration	PCMH+ has promoted deeper penetration of physical health-behavioral health integration at the majority of PEs evaluated and in an array of areas including: BH screening beyond depression, screening for substance use disorders, warm transfers for members screening positive for BH conditions, hiring BH ECCs when not required (e.g., in Advanced Network) and use of interdisciplinary teams that include BH representation.
	Several PEs were using group sessions to build Wellness Recovery Action Plans with members.
	The FQHCs that are required to develop Wellness Recovery Action Plans with eligible members demonstrated adoption of recovery planning tools, some using nationally recognized tools and other PEs adapting nationally recognized tools, to create their recovery planning tool. Development of Wellness Recovery Action Plans is not currently a requirement for Advanced Networks.

PROGRAM STRENGTHS

AREA	STRENGTH
Competencies Caring for Individuals with Disabilities	Many PEs demonstrated assessments that included evaluation of a member's ability to perform activities of daily living, instrumental activities of daily living, durable medical equipment needs and other home modification needs. This was identified as a best practice.
	All PEs exhibited some level of modified accommodations for members with disabilities. All could provide language interpretation supports and longer appointment times. Many had adaptive equipment such as adjustable exam tables and wheel chair scales and flagged members with disabilities within their electronic health records to alert all staff, including those making appointments, of members who may require longer appointment times.

PROGRAM STRENGTHS

AREA	STRENGTH
Culturally Competent Services	All PEs provided some level of training to staff around cultural competency. Most training was conducted at the time of hire and annually thereafter. Several PEs conduct expanded cultural training for staff including competencies with LGBTQ individuals and offering unconscious bias training.
	The majority of PEs actively hire a diverse workforce that is reflective of their member population and geographic service area(s). In addition, most of the ECCs and BH ECCs hired for PCMH+ are bilingual in an array of languages, not just Spanish.
	Nearly all PEs screened and assessed a member's cultural preferences with evidence of such assessments in the member's file. Preferences assessed included race, ethnicity, learning needs, literacy, health literacy, dietary preferences based on culture, and family customs.
	Identified as a promising practice, at least two PEs have expanded their cultural assessments to include a member's gender identity and gender pronoun preference and one PE has updated bathrooms at their sites to be gender neutral.

PROGRAM STRENGTHS

AREA	STRENGTH
Community Linkages	Many PEs participate in local community collaborative meetings that bring a variety of community providers together to drive improved access for members to resources.
	All PEs were assessing members for social determinants of health and while not seen at all PEs, several were using standardized social determinants of health screening tools. Use of a standardized tool is noted as a best practice for the program.
Member Interviews	Members were overwhelmingly positive about their care and their ECC's support. Many shared examples of how their ECC had assisted them with needs related to social determinants of health.

PROGRAM OPPORTUNITIES

AREA	OPPORTUNITY
Program Administration	ECC contacts, relative to the PE PCMH+ membership, across the majority of PEs are low, but are consistently trending upward since reporting began April 2017. PE PCMH+ monthly reports are posted on the DSS PCMH+ website.
	Some PEs have experienced challenges recruiting members for participation on the PCMH+ advisory board, despite offering some level of member support such as child care, food at the meetings, assistance in transportation and having a PCMH+ staff person to assist members to navigate agendas and materials. Participation varies from a low of zero PCMH+ members to a high of 16 PCMH+ members at one PE.

PROGRAM OPPORTUNITIES

AREA	OPPORTUNITY
Program Administration	Many PEs report utilizing multiple electronic health record systems. The adaption of these electronic health records to meet program requirements was often shared as a challenge and expense for the PEs. Additionally, use of multiple electronic health records created challenges in the sharing of information across EHR platforms. This could require staff to operate multiple platforms, or for some staff, a lack of access to the electronic health record systems that contained PCMH+ member information.
	All PEs had a quality program; however, several had not incorporated PCMH+ into their existing quality programs or demonstrated how the PCMH+ program will be evaluated in the quality plan.
	Both Advanced Networks were requested to provide updated documentation to demonstrate that all sites were on track to achieve PCMH recognition or certification within the required 18-month timeframe from program go-live. This information is reported by the Advanced Networks within the PCMH+ monthly reports and progress is monitored by DSS.

PROGRAM OPPORTUNITIES

AREA	OPPORTUNITY
Physical Health-Behavioral Health Integration	There was an opportunity identified for PEs to consistently ask members about Wellness Recovery Action Plans and psychiatric advance directives, and to include this information within the member's file.
	The development of Wellness Recovery Action Plans or similar recovery planning tools was a new concept for the majority of PEs prior to PCMH+ and incorporation of Wellness Recovery Action Plans within the member's plan of care varied across the organizations. The majority of PEs welcomed future technical assistance around Wellness Recovery Action Plans.
Underservice	While there was no evidence of underservice noted during the reviews, DSS recommended that all PCMH+ PEs have or develop an underservice methodology to monitor, prevent and address under-utilization of clinically appropriate services that may be shared with DSS as requested.

PROGRAM OPPORTUNITIES

AREA	OPPORTUNITY
Children and Youth with Special Health Care Needs	The identification of Children and Youth with Special Health Care Needs and Transition Age Youth (and in addition, members with disabilities) posed challenges for some PEs. Many PEs shared their difficulty flagging special populations within their electronic health record systems to ensure these populations were known to treating staff. In addition, many indicated a desire to have DSS more specifically define the population to support the PE's identification of Children and Youth with Special Health Care Needs and Transition Age Youth.
	Evidence of advanced care planning for Children and Youth with Special Health Care Needs was not consistent across the PEs. Many were building definitions and identification methods for this population. In addition, most PEs reported that special needs children were frequently served by children's hospital organizations within their area, leaving a small population of children that potentially meet the Children and Youth with Special Health Care Needs definition.

PROGRAM OPPORTUNITIES

AREA	OPPORTUNITY
Children and Youth with Special Health Care Needs	Obtaining individualized education plans and 504 plans was universally reported as a challenge. Even for PEs operating several school-based health centers, communication and coordination with the schools was limited.
	For PEs able to obtain individualized education plans and 504 plans, there was evidence of incorporation of the information into the member's plan of care; however, this was inconsistent and represents an opportunity area.
Competencies Caring for Individuals with Disabilities	Identification of members with disabilities posed challenges for the some PEs. Many PEs shared difficulty flagging special populations within their electronic health record systems and indicated a desire to have DSS develop a standardized definition of members with disabilities to support the PE's identification of this population.

Q&A SESSION

Question Submission Instructions

- Lines are muted- Submit questions through Zoom Chat Function
- Submit to “Everyone”

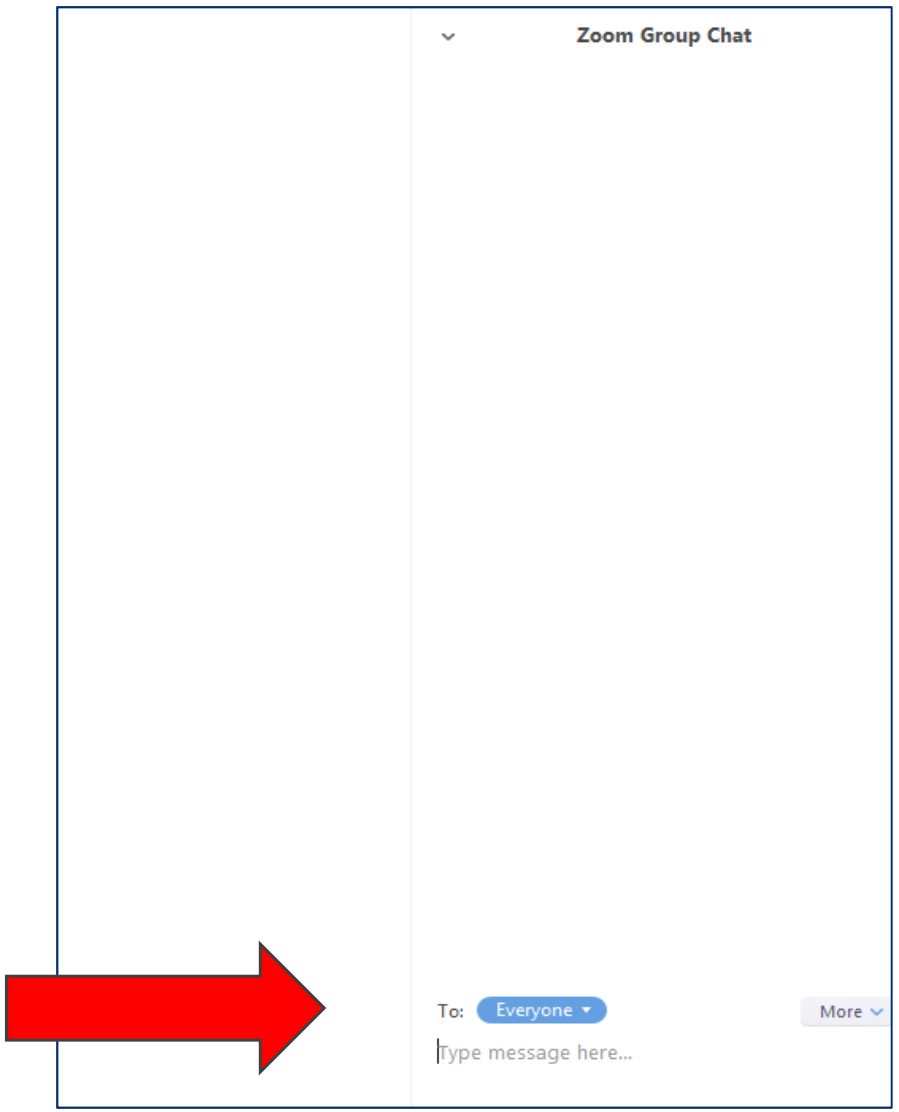
If you prefer to submit your question(s) directly to DSS please send to:

Robert.Zavoski@ct.gov

or

Nicole.Godburn@ct.gov

DSS will respond to your questions and post to the PCMH+ website



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