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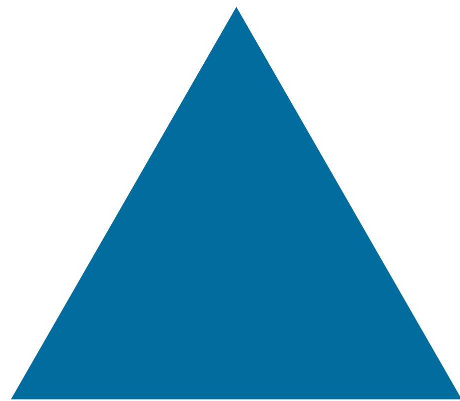
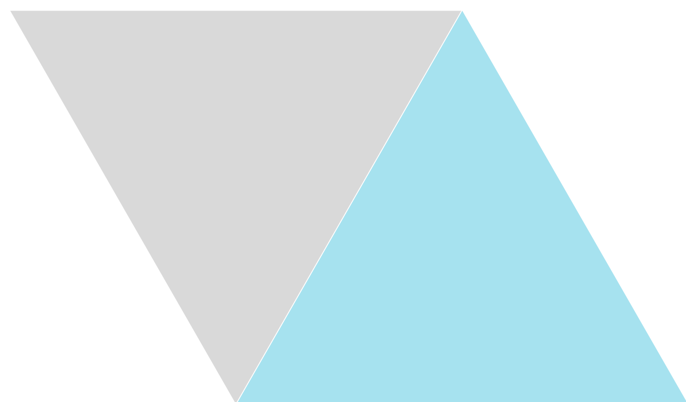


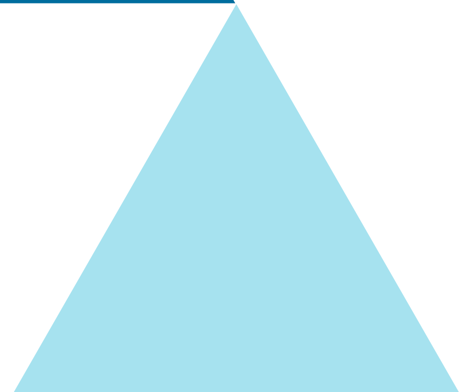
2018 PCMH+ LEGACY PE DESK REVIEW

CHARTER OAK HEALTH CENTER

JANUARY 4, 2019

State of Connecticut





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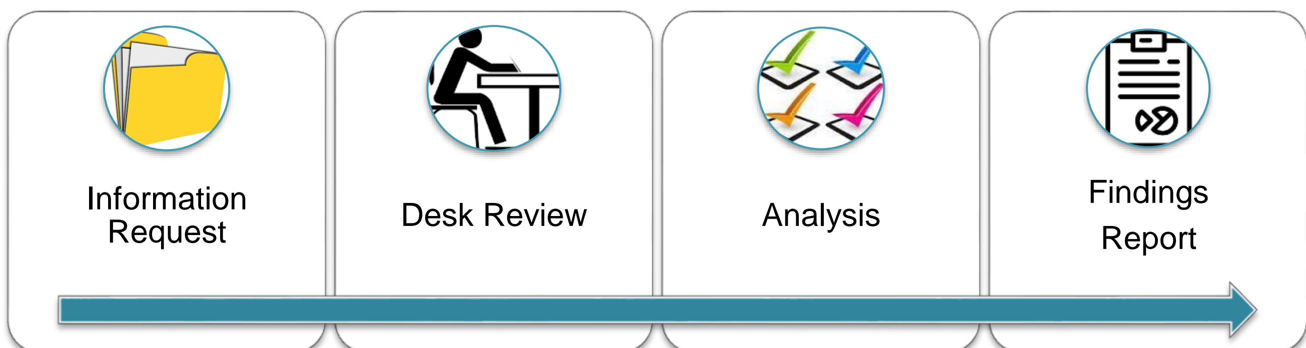
1
INTRODUCTION

The State of Connecticut Department of Social Services (DSS) has retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS Person-Centered Medical Home Plus (PCMH+) program. In collaboration with DSS, Mercer conducted an initial compliance review in 2017 of the Wave 1 Participating Entities (PEs), also known as Legacy PEs. The review assessed for compliance, quality, and effectiveness in achieving the goals of the PCMH+ program for the period of January 1, 2017 (the program go-live date) to July 2017 and included both a desk review and onsite review. Wave 1 Compliance Assessment Reports were developed for each PE as a result of the Wave 1 compliance review. Individual PE Assessment Reports included detailed findings, areas of strength, and recommendations for improvement. Wave 1 Assessment Reports were publically released in November 2017 and can be found at the DSS website: https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Documents

Given the comprehensive nature of the Wave 1 compliance review, as well as the ongoing monthly and quarterly monitoring of the PEs, Legacy PEs will undergo only a desk review during Wave 2 of the PCMH+ program. The Wave 2 desk review examined the period between July 1, 2017–June 30, 2018. The Wave 2 desk review evaluated the PEs progress towards completing Wave 1 recommendations for improvement outlined in the Wave 1 Assessment Reports as well as evaluating the maturity of the PCMH+ program in Wave 2. The Wave 2 review period includes a month of overlap with the Wave 1 compliance review to allow for a full year to be included as part of the Wave 2 desk review. The review was organized into four phases presented in the following diagram:



INFORMATION REQUEST — JULY TO AUGUST 2018

Mercer submitted an information request to each PE. The information request was designed to seek documents and materials to provide insight into the status of the PE's PCMH+ program since the Wave 1 compliance review. The information request required the completion of a questionnaire titled the "Legacy PE Desk Review Questionnaire" and the submission of a sample of 20 member records for a member file review. The questionnaire asked the PEs to respond to a series of questions regarding overall program status, successes and challenges, programmatic and/or operational changes, development of new member materials, development of new PCMH+ policies and procedures, and implementation of new training materials. The questionnaire was customized to each PE according to the individualized recommendations for improvement as outlined in each PE's summary report from the 2017 Wave 1 compliance review (see Appendix A for the customized questionnaire for this PE). PEs were also asked to submit supporting documentation as necessary to supplement the narrative responses.

DESK REVIEW — SEPTEMBER 2018

Mercer received information electronically from the PEs and conducted a desk review of all submitted documentation. The desk review was part of an overall evaluation process designed to assess PE compliance with the PCMH+ program. As part of the review process, an optional summary conference call was available for request by either the PE and/or DSS to review clarifications on desk review submissions.

ANALYSIS AND FINDINGS REPORT — NOVEMBER 2018

During all phases of the Wave 2 evaluation, information was gathered and a comprehensive review was performed. The following sections contain the results from the comprehensive analysis of Charter Oak Health Center including; a review of progress made towards the 2017 recommendations for improvement, identified areas of improvement from the 2018 desk review and DSS' plans for future monitoring of program performance.

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SUMMARY OF FINDINGS

CHARTER OAK HEALTH CENTER PCMH+ PROGRAM OVERVIEW

Charter Oak Health Center (COHC) is a Federally Qualified Health Center that provides an array of primary care and specialist care to its members including behavioral health (BH), cardiology, dental, nutrition, lab and radiology, optometry, pain management, pediatrics, pharmacy, podiatry, urology, and women's health throughout Hartford, Connecticut. COHC operates at two sites in Hartford and offers extended hours (until 6:00 pm during the week, and Saturday and Sunday hours). Additional services include a mobile dental clinic, two school-based health centers, medical services at seven homeless shelters, community outreach and entitlement enrollment services.

Under PCMH+, COHC provides enhanced care coordination activities to 8,124 PCMH+ members. COHC increased staffing for PCMH+ to include six Community Health Workers (including one BH Community Health Worker). Four of the Community Health Workers are 100% dedicated to the PCMH+ program. These Community Health Workers interface directly with PCMH+ members to help develop individualized care plans and establish relationships to assist members on their journey to wellness. The Community Health Workers report to the PCMH+ Program Lead Registered Nurse (RN), who supervises and directs the workflow of the Community Health Workers as well as develop care plans, create member engagement/assessment tools and develop forms, systems and processes. The PCMH+ Program Lead RN reports to the PCMH+ Clinical Director and advanced practice RN, who serves as a liaison to the primary care clinicians. Weekly meetings are held between the PCMH+ Program Lead RN and the PCMH+ Clinical Director to review and discuss PCMH+ program issues. Leadership involvement in the Wave 2 PCMH+ program was also expanded to include the Chief Medical Officer, Director of Clinical Services and Chief of Quality Assurance.

COHC continues to utilize a team-based approach to serve 8,124 PCMH+ members in Wave 2 of PCMH+ (Wave 1 attribution totaled 6,870 members). In Wave 1, COHC's demonstrated an average penetration rate of 10.36%. In Wave 2, COHC's average penetration rate dropped to 2% but overall, has demonstrated an average penetration rate of slightly less than 9%.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

Initially, COHC began with "clinical champions", a PCMH+ designated supervising nurse and a team of Community Health Workers. Periodically, additional personnel from Quality, Operations, the front desk, as well as clinical analysts and supervisors, were added to monitor, manage and improve outcomes, reduce cost and expand community engagement. Wave 1 of PCMH+ was spent engaging patients, training Community Health Workers and understanding workflow processes required for PCMH+. Community Health Workers made over 4,000 phone calls in the first year of the program. In Wave 2, COHC has focused on enhanced member engagement and outreach beyond phone calls to increase identification of social determinants of health (SDoH), as well as any

other barriers that may impact COHC's ability to respond to members' healthcare needs. COHC's conducts outreach to a subset of 400 members diagnosed with four or more of the following chronic illnesses: Obesity, hypertension, diabetes, asthma or depression. These members are assigned to a Community Health Worker who meets with the member in person at COHC's facility or in the member's home to assess their SDoH using a standardized tool called Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE). Community Health Workers create care plans for members addressing diagnoses and identifying SDoH, as well as providing other assistance such as helping schedule appointments. Community Health Workers also provide pledge forms for patients to sign in which they agree to work with their Community Health Worker, participate in education and other programs as needed and be accountable for their own medical appointments.

COHC also identified other patients requiring care coordination beyond this group by reviewing Community Health Network of Connecticut (CHN-CT) reports, including the Daily Admission and Discharge Report, Emergency Department Utilization Report, Adult Diabetes Screening Tests Gaps in Care and Child Well-Care Visits Gaps in Care. COHC reports an improvement in closing gaps in care due to these care coordination activities.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

- COHC purchased Smart Forms for their electronic medical record and incorporated the forms into the workflow. The forms are completed during patient visits and included in progress notes that are available to providers. This has allowed each team member to identify and address members' needs while they are in the facility.
- To enhance quality, daily safety huddles are held in each department and are an opportunity to discuss members scheduled to come in that day, to attend to their gaps in care and to schedule future appointments.
- COHC's workers are seen as vital in initiating and maintaining a strong relationship with patients. Community Health Workers have attended over 25 community outreach events in 2018. The Community Health Workers hosted a luncheon at COHC where Community Health Workers from other Federally Qualified Health Centers came together to discuss the significance of Community Health Workers and their importance in care coordination and improving patient health outcomes.
- Community Health Worker involvement in member wellness includes the following:
  - Standing orders have been instituted for nurses to be able to obtain an A1c from patients if due, which allows the Community Health Worker to identify and automatically schedule patients to have an A1c performed.
  - In order to increase emergency department follow-up visits within seven days of discharge, CHN-CT provides a list of recently discharged emergency department patients for the Community Health Workers to call and schedule a follow-up appointment with the patient's primary care provider, follow up to see if the visit was completed, and if necessary, call and reschedule the patient.

- The Community Health Workers are also trained to complete health risk assessments and develop patient care plans. New training developed for the Community Health Workers since the last compliance review include the following:
  - General Safety Training
  - 2018 Compliance Training
  - Community Health Worker 56-Hour Core Competency Training (Southwestern Area Health Education Center)
  - Futures Without Violence: Trauma Informed Approaches to Address Intimate Partner Violence and Human Trafficking
  - 16-hour Motivational Interviewing
  - 8-hour Mental Health First Aid
  - Oral Health Training for Community Health Workers
  - Asthma Home Visiting Training for Community Health Workers
  - De-Escalation and Engagement Strategies: A Trauma-Informed Approach

COHC involves members in innovative ways, such as through participation in the Consumer Advisory Council and involvement in COHC's National Health Week festivities. COHC also offers exercise and wellness groups to members and has had over 650 member visits this year, which include Zumba, Yoga and group walks. COHC gives members food scales and a machine to monitor blood pressure. Member wellness education developed since the 2017 compliance review includes:

- Empowered to Serve (Hypertension Education Series)
- Unmasking Hepatitis C: Get the Facts, Get Support, Take Action
- Ending Hepatitis B Starts with you: Protect Yourself, Protect Your Loved Ones
- Cooking Matters
- Perfect Portions
- Weight Management
- Diabetes Drop-In

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

COHC reported several challenges encountered during both Wave 1 and Wave 2 of PCMH+. The majority of the challenges experienced are outside of the scope of this review. These included, but are not limited to, missed medical appointments regardless of reminder calls and an inability to effectively document productivity and patient engagement in the electronic medical record.
In Year 1, transitioning leadership was an additional barrier but stable leadership in Year 2 is allowing COHC to address identified challenges.

Another ongoing barrier has been around obtaining completed Wellness Recovery Action Plans since some COHC patients choose to have their BH needs met outside of COHC. COHC is addressing this issue by embedding the BH clinician in the pediatric practice and building better relationships with partners such as The Village for Children & Families and The Institute for Hispanic Family.

RECOMMENDATIONS FOR IMPROVEMENT FROM THE **2017** COMPLIANCE REVIEW

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Physical Health-Behavioral Health (PH-BH) Integration	Formalize procedures to develop Wellness Recovery Action Plans with members.	When a member has a substance use disorder or a chronic mental illness, a Wellness Recovery Action Plans is created. COHC utilizes a group process to facilitate the development of Wellness Recovery Action Plans. The group, called Wellness Recovery Action Plans Group-Pathways to Recovery, was put together in June 2018 and is led by BH clinicians. The group utilizes tools such as the Pathways to Recovery: A Strengths Recovery Self-Help Workbook to guide the discussion and development of Wellness Recovery Action Plans.	Met
Children and Youth with Special Health Care Needs (CYSHCN)	Develop a process to identify CYSHCN that allows staff to accurately identify this population for outreach and support assessment.	COHC developed a written process for the Pediatric department emphasizing communication with the Community Health Workers to focus on patients with special needs who may need extra support. Additionally, there is an opportunity on the intake form for the patient or patient's guardian to indicate if the child has special health care needs. Each school-aged child is identified as having an individualized education plan (IEP) or 504 Plan. Members are also identified in the electronic medical record.	Met

[1] **Met** = No further action or review required. The PE provided sufficient evidence to satisfy the recommendation for improvement.

Partially Met = Further action and/or review may be required. The PE provided partial evidence to satisfy the recommendation for improvement. Further clarification or efforts to address the recommendation may be required.

Not Met = Further action and/or review required. The PE did not provide sufficient information to satisfy the recommendation for improvement. Further efforts are to address the recommendation are required.

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Competencies in Care for Individuals with Disabilities	Complete the assessment and include adaptive equipment for members as needed.	COHC assists members with mobility impairments by utilization of ramps, larger corridors, adjusted height and extra leg room at check in/out desk, special exam rooms and wheelchairs at the main reception areas. All departments have the same ADA structural features and adaptive equipment available. COHC uses a language line for members who need interpretation. The demographic form captures barriers for members including the need for interpretation, sliding fee assistance, assistance with paperwork for lapse in insurance and the need for a longer visit time. These policies are specified in the Language Access Plan Policy and Patient Non-Discrimination Policy. Although COHC reported the above accommodations for individuals with disabilities, the chart review found that COHC does not consistently document the adaptive support utilized by members with disabilities.	Partially Met
Member File Reviews	Create a process to identify Transition Age Youth and CYSHCN that could benefit from enhanced care coordination. Consider evaluation of need for individual and family resources.	COHC has developed a workflow and a set of criteria to identify Transition Age Youth and CYSHCN who might benefit from enhanced care coordination. Referrals can be generated through the electronic medical record and may be issued by a COHC's pediatric provider or other provider who encounters the child/youth. Transition Age Youth and CYSHCN are also flagged in the electronic medical record under a "global alert" which can be viewed by any team member who has access to the member's file. Despite these efforts, COHC reported a drop in the number of CYSHCN and Transition Age Youth members served by COHC. Additionally, the chart review found that COHC continues to provide limited or absent outreach for care coordination to Transition Age Youth and CYSHCN.	Partially Met

IDENTIFIED OPPORTUNITIES FOR IMPROVEMENT FROM THE **2018** DESK REVIEW

AREA	OPPORTUNITY	RECOMMENDATION
PH-BH Integration	COHC does not consistently assess members with BH conditions for the presence of a psychiatric advance directive or obtain a copy for the member file.	Formalize procedures to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member records.
	COHC does not have a process in place to develop transition plans with Transition Age Youth.	Formalize procedures to develop transition care plans with Transition Age Youth in order to engage them in transition care planning.
CYSHCN	COHC continues to provide limited or absent outreach for care coordination for Transition Age Youth and CYSHCN.	Formalize procedures to increase the number of Transition Age Youth and CYSHCN provided with care coordination services.
Competencies in Care for Members with Disabilities	COHC does not consistently document the adaptive supports utilized by members with disabilities.	Formalize procedures to assess for and document the adaptive supports utilized by members with disabilities in the electronic medical record.
Cultural Competency	COHC does not assess the cultural needs and preferences of pediatric members.	Formalize procedures to assess the cultural needs and preferences of pediatric members.

RESULTS

The results of the 2018 desk review indicate that COHC has continued to demonstrate progress or has met the requirements of the recommendations for improvement from 2017. Additionally, COHC is currently initiating efforts to address some of the opportunities for improvement identified in the 2018 desk review and therefore, no corrective action plan will be issued at this time. Monitoring of progress towards completion of the 2018 opportunities for improvement will occur through ongoing quarterly PE reporting and/or through other mechanisms identified at the discretion of DSS.

3
DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

A. PCMH+ Program Operations Requirements

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

- Having an oversight body, supporting PCMH+ which includes substantial representation by PCMH+ members.
- Having a senior leader and a clinical director providing oversight for the PCMH+ program.
- Having sufficient care coordination staff to provide the enhanced care coordination required activities to provide timely care coordination to PCMH+ assigned members.
- Completing and submitting the PCMH+ monthly and quarterly report based on specifications provided by DSS.

B. PCMH+ Program Operations Findings

- COHC did not have any recommendations for improvement from the 2017 compliance reviews in this area. However, monitoring of an existing oversight body with substantial representation by PCMH+ members, the assignment of a senior leader and clinical director to oversee the PCMH+ program and having sufficient care coordination staff to provide required enhanced care coordination activities is completed through monthly and quarterly reporting. COHC has consistently met these requirements. COHC has also completed and submitted the PCMH+ report on a timely basis each month and now on a quarterly basis.
- COHC holds PCMH+ Patient Advisory Meetings and Consumer Advisory Council meetings, both substantial with PCMH+ member participation. COHC reported that in Year 2, 12 PCMH+ members participated in the three meetings held so far. COHC also hosts lunch as part of the PCMH+ advisory meetings.
- It is unclear if COHC has the same clinical leadership as last year due to incomplete report submission.
- COHC increased staffing for PCMH+ to include six Community Health Workers (including one BH Community Health Worker). Four of the Community Health Workers are 100% dedicated to the PCMH+ program.

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 high risk, high cost members 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

- Based on the results of the 2017 compliance reviews, COHC did not have any recommendations for improvement in this area. No underservice was noted during the review.
- PCMH+ Executive Team Leads review center-wide member complaints to determine if there are any member complaints indicating an effort from staff to discourage members from accessing services.
- COHC also uses their "Code of Conduct" training to educate staff that underservice or panel manipulation is prohibited. In the event that underservice or panel manipulation is suspected or identified, the Chief of Compliance & Legal Affairs, one of the PCMH+ Program's Executive Team Leads, will immediately launch an investigation and take any corrective action deemed necessary to prevent a recurrence.

ENHANCED CARE COORDINATION

A. 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.
- Obtaining and maintaining a copy of a member's Wellness Recovery Action Plan in the member's file.
- For Federally Qualified Health Centers only: Develop Wellness Recovery Action Plans in collaboration with the member and family.
- For Federally Qualified Health Centers only: Expand development and implementation of the care plan for Transition Age Youth with BH challenges.
- For Federally Qualified Health Centers only: Utilize an interdisciplinary team that includes the Behavioral Health Care Coordinator.

B. PH-BH Integration Findings

- Based on the 2017 compliance review, it was recommended that COHC formalize procedures to develop Wellness Recovery Action Plans. At the time of the 2017 compliance review, COHC was still developing their Wellness Recovery Action Plan processes. COHC currently utilizes a group process to assist with the development of Wellness Recovery Action Plans. The group is led by BH clinicians and utilizes tools such as the Pathways to Recovery: A Strengths Recovery Self-Help Workbook to guide the discussion and development of Wellness Recovery Action Plans. Monthly/quarterly reporting has shown significant improvement in obtaining and maintaining Wellness Recovery Action Plans in files.
- It was also recommended that COHC identify Transition Age Youth who could benefit from enhanced care coordination. A review of member files demonstrated that COHC does not have a process in place to develop transition plans with Transition Age Youth. Additionally, the member file review and monthly/quarterly reporting indicated that COHC continues to provide limited or absent outreach for care coordination for Transition Age Youth.
- Counts of members with BH conditions, the number of BH screenings completed, the number of psychiatric advance directives obtained for the member files and the number of interdisciplinary team meetings is also monitored through monthly and quarterly reports. COHC has consistently demonstrated the ability to identify members with BH conditions in their electronic medical records and to report on all of these data points.
- Additionally, COHC continues to conduct universal screening for BH conditions and utilize tools such as the Patient Health Questionnaire (PHQ) 2/9, the Generalized Anxiety Disorder 7-item scale (GAD-7), the Columbia Suicide Severity Rating Scale (C-SSRS), CAGE-AID, Screening, Brief Intervention, and Referral to Treatment (SBIRT) (an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs), Audit-C (alcohol screen) and the CRAFFT screening tool for adolescent substance use.
- Although not a recommendation for improvement in the 2017 compliance reviews, the member file review indicated that COHC does not consistently assess members with BH conditions for the presence of a psychiatric advance directive or obtain a copy for the member file.
- Finally, the monthly/quarterly reports show that COHC holds regular interdisciplinary team meetings with Behavioral Health Care Coordinator participation.

A. CYSHCN Requirements

CYSHCN and their families often need services from multiple systems — health care, public health, education, mental health and social services. PCMH+ CYSHCN requirements include:

- Holding advance care planning discussions for CYSHCN.
- Developing advance directives for CYSHCN.
- 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. CYSHCN Findings

- Based on the 2017 compliance review, it was recommended that COHC create a process to identify CYSHCN who could benefit from enhanced care coordination, as well as a process that allows staff to accurately identify and outreach this population and support assessment. COHC developed a workflow for the Pediatric department to identify CYSHCN and Transition Age Youth. Additionally, CYSHCN are identified in the electronic medical record and there is an opportunity on the intake form for the member or member's guardian to indicate if the child has special health care needs. The presence of an IEP or 504 Plan is also identified for relevant school-aged children.
- While it is evident that COHC has made progress in this area, COHC reported a drop in the number of CYSHCN compared to 2017 on monthly and quarterly reports; counts of CYSHCN dropped from 21 to two members. Additionally, the member file review found that COHC continues to provide limited or absent outreach for care coordination for CYSHCN.

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, BH 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, mental 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

- Based on the results of the 2017 compliance reviews, it was recommended that COHC complete the assessment of need for adaptive equipment in service sites for members with disabilities and include adaptive equipment for members as needed. All COHC departments have the same ADA structural features and adaptive equipment available, including:
  - ADA structural features and adaptive equipment at COHC's Pediatric department such as a ramp, elevator to accommodate access from the first floor to the Department, and interior corridor dimensions designed and built to accommodate access.
  - Reception area check-in and check-out desk was designed and built to meet ADA-appropriate height and leg room, bariatric location provided in the waiting area, an ADA accessible exam room.
  - Adaptive equipment such as an ADA-accessible exam table and cabinetry, wheelchairs at the main reception areas.

- COHC also uses a language line for patients who need interpretation. The demographic form captures barriers for patients including the need for interpretation, sliding fee assistance, assistance with paperwork for lapse in insurance and the need for a longer visit time. These policies are specified in the Language Access Plan Policy and Patient Non-Discrimination Policy.
- Although COHC has made these accommodations for members with disabilities, the member file review found that COHC does not consistently document the adaptive support utilized by members with disabilities. It is also unclear how members are categorized as an individual with a disability and whether COHC completes assessments for adaptive supports.
- COHC did not have any other recommendations for improvement in this area. However, counts of members with disabilities and care coordination activities pertaining to their care are monitored in monthly and quarterly reporting. Based on this reporting, COHC made four adjustments in appointment times for members with disabilities this year, and while low, it does represent an improvement over zero adjusted appointments provided last year.

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 SDoH 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

- Based on the results of the 2017 compliance reviews, COHC did not have any recommendations for improvement in this area. A review of member files indicates that COHC consistently assesses adult members for cultural needs and preferences, including race, ethnicity, primary language, preferred language, sexual identity, whether the member has language barriers that impact care and whether the member is a migrant worker or a farm worker. However, these same cultural needs and preferences were not assessed for pediatric members.
- According to monthly and quarterly reporting, the required annual staff cultural competency training was held in 2017.

A. Community Linkage Requirements

In an effort to meaningfully impact PCMH+ members' SDoH, 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, 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

- Based on the results of the 2017 compliance reviews, COHC did not have any recommendations for improvement in this area. Community linkage requirements are monitored through monthly and quarterly reporting. The member file review showed that COHC continues to utilize a comprehensive SDoH assessment, PRAPARE, which assesses elements such as housing stability and safety, educational level, employment status, sources of income, access to transportation, social supports, criminal justice involvement and if the individual is a refugee or immigrant. Results of the SDoH assessment are incorporated into clinical records alongside medical notes. There is clear evidence of assessments of SDoH, referrals to community resources and follow-up with members to ensure needs are met.

MEMBER FILE REVIEWS

A. Member File Review Process

PEs were instructed to provide 20 of the following member files:

- Five files representative of members who have been linked to community resources to address SDoH in the review period.
- Five files representative of PCMH+ members who have a BH condition and have received care coordination in the review period. PEs are encouraged to select members who have Wellness Recovery Action Plans or other recovery planning tools.
- Five files representative of PCMH+ members who are a Transition Age Youth or CYSHCN and have received care coordination in the review period. Ensure this sample includes at least one Transition Age Youth and one CYSHCN.
- Five files representative of PCMH+ members who have a disability and have received care coordination in the review period.

Mercer asked that files include:

1. A demographic description or demographic page which should include at a minimum: member name, member ID, date of birth, gender and preferred language.
2. The most recent member assessment, including an assessment of SDoH.
3. Most recent plan of care. If assessed cultural needs and preferences are located elsewhere in the member file, copies of this documentation may be provided in addition to the plan of care.

4. Care coordination progress notes, including, but not limited to, referrals to community resource agencies that address SDoH for the specified timeframe. Please note this does not include physician progress notes.
5. Results of most recent BH screening(s).
6. Advance care directive for members with BH conditions (if applicable to the member). If declined by the member, progress notes or other evidence may be provided showing the PE's efforts.
7. Copy of Wellness Recovery Action Plans or other recovery tool (if applicable to the member).
8. Transition Age Youth transition plan of care (if applicable to the member).
9. Evidence of advance care planning discussions or care plans for CYSHCN (if applicable to the member).
10. Copies of IEPs or 504 Plans (if applicable to the member). If not able to obtain, progress notes may show the PE's efforts to obtain the documents.
11. Other documentation the PE believes is relevant to the review process and demonstrates compliance with PCMH+ requirements.

Reviewers included two Mercer representatives (a licensed social worker and an RN) who reviewed a total of 20 member files.

B. Member File Review Findings

- COHC continues to utilize a comprehensive SDoH assessment, PRAPARE, which assesses elements such as housing stability and safety, educational level, employment status, sources of income, access to transportation, social supports, criminal justice involvement and if the individual is a refugee or immigrant. Results of the SDoH assessment are incorporated into clinical records alongside medical notes. Of note, not all members are screened for SDoH, either informally or formally via the SDoH assessment. This was particularly evident for CYSHCN and Transition Age Youth.
- Community Health Worker's work document their interactions with members in the electronic medical record. There is clear evidence of assessment of SDoH, referrals to community resources and follow-up with members to ensure needs are met. Community Health Workers also assist members with coordination of care regarding medical appointments and follow-up, offer self-management techniques for issues such as diabetes, asthma and overall wellness.
- COHC consistently assesses adult members for cultural needs and preferences, including race, ethnicity, primary language, preferred language, sexual identity, whether the member has language barriers that impact care and whether the member is a migrant worker or a farm worker. These same cultural needs and preferences were not assessed for pediatric members.
- COHC screens members for BH conditions, include substance use. Screening tools include the PHQ 2/9, GAD-7, C-SSRS, CAGE-AID (a substance use screener), SBIRT, Audit-C (an alcohol screen) and the CRAFFT screening tool for adolescent substance use.
- For members with BH challenges, COHC did not provide evidence of consistently assessing for psychiatric advance directives.

- COHC utilizes a group process to facilitate the development of Wellness Recovery Action Plans. The group, called Wellness Recovery Action Plans Group-Pathways to Recovery, is led by BH clinicians and utilizes tools such as the Pathways to Recovery: A Strengths Recovery Self-Help Workbook to guide the discussion and development of Wellness Recovery Action Plans. Although, it is unclear how members are identified for the group.
- COHC does not have a process in place to develop transition plans with Transition Age Youth.
- COHC continues to provide limited or absent outreach for care coordination for Transition Age Youth and CYSHCN.

APPENDIX A

LEGACY PE DESK REVIEW QUESTIONNAIRE

Please provide concise responses to all questions and limit total responses to a maximum of 5 pages. The page limit is not inclusive of attachments.

1. Written summary of PCMH+ program implementation and progress to date.
2. Written summary of PCMH+ program successes.
3. Written summary of PCMH+ program barriers and challenges encountered.
4. Written summary of major PCMH+ programmatic and/or operational changes (e.g., changes or updates to electronic health systems, expansion of programs, etc.).
5. Examples of PCMH+-specific member materials (e.g., education and communication materials) that have been developed following the 2017 compliance reviews.
6. New PCMH+ policies and procedures that have been approved since the last review.
7. New PCMH+-related training materials for staff members that have been put into place since the last review.
8. Written response to recommendations for improvement as outlined in the PE's summary report from the 2017 compliance review and included below. Note: Some evidence of improvement may be found during the member record review process (as applicable to the recommendation for improvement).

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
PH-BH Integration	COHC is still developing their Wellness Recovery Action Plan processes, but currently asks members if they have a Wellness Recovery Action Plan and incorporates that information into the member's plan of care.	Formalize procedures to develop Wellness Recovery Action Plans with members.
CYSHCN	COHC is still developing processes to identify CYSHCN. COHC has developed an addendum to the intake form specifically for children.	Develop a process to identify CYSHCN that allows staff to accurately identify this population for outreach and support assessment.
Competencies in Care for Individuals with Disabilities	COHC is in the process of assessing the need for adaptive equipment in their service sites for members with disabilities.	Complete the assessment and include adaptive equipment for members as needed.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Member File Reviews	There is an opportunity to identify Transition Age Youth and CYSHCN that could benefit from enhanced care coordination. Files representing these types of members demonstrated no outreach for care coordination at the time of the file review. Identification of these types of members will offer opportunity to evaluate their care coordination and/or resource needs.	Create a process to identify Transition Age Youth and CYSHCN that could benefit from enhanced care coordination. Consider evaluation of need for individual and family resources.

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