HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

GENERATIONS FAMILY HEALTH CENTER

JANUARY 4, 2019

State of Connecticut

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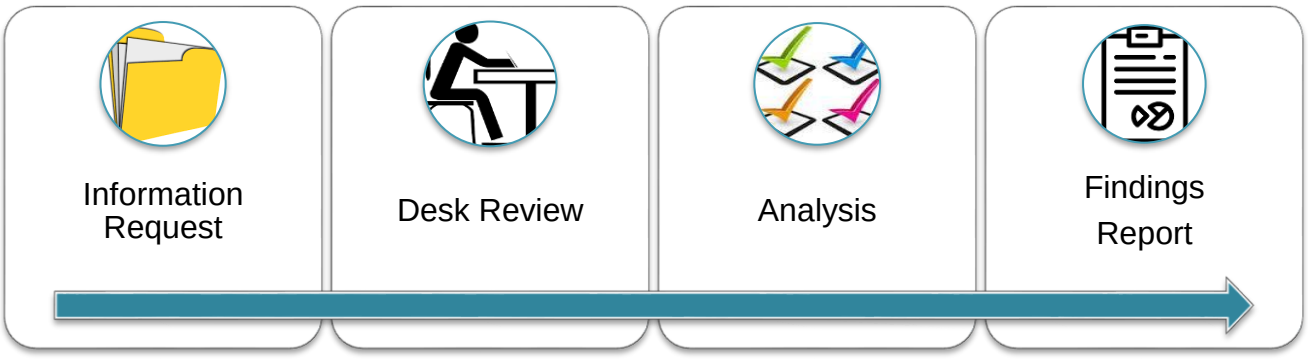
INTRODUCTION

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 Generations Family Health Center (GFHC) 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

GENERATIONS FAMILY HEALTH CENTER PCMH+ PROGRAM OVERVIEW

Generations Family Health Center (GFHC) is a Federally Qualified Health Center serving 37, mostly rural, towns in eastern Connecticut. GFHC provides a full continuum of primary care and specialist care to its members including: behavioral health (BH), chronic disease management and dental care and offers extended hours throughout the week (until 8:00 pm). Additional services include community outreach, health education and enrollment services, a mobile dental clinic, one school-based health center and enhanced access and services for the homeless, farmworkers, Children and Youth with Special Health Care Needs (CYSHCN) and HIV/AIDS/Hepatitis-C members.

Under the PCMH+ program, GFHC provides enhanced care coordination activities to 7,879 PCMH+ members (4:1 ratio adults to children). Staffing for PCMH+ includes 6.70 FTE Care Coordinators (six 1.0 FTE Care Coordinators, one .20 FTE Care Coordinator and one .50 FTE Behavioral Health Care Coordinator). GFHC has assigned one Care Coordinator to each of their medical and BH sites. All Care Coordinators report to the System of Care Manager who supervises the team and provides program oversight.

GFHC has consistently demonstrated a strong penetration rate over the review period. In the first quarterly report of 2018, 2,725 unique PCMH+ members received a care coordination or BH care coordination contact (a total of 908 members per month). With an attributed membership of 7,879, that is a penetration rate of 12%.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

Care Level Assessment and Social Determinants of Health (SDoH)

GFHC formalized the process for care level assessment and scoring to identify members in need of care coordination and identify them in the GFHC health record database. If any staff member encounters a “trigger” for potential care coordination, such as a recent hospital visit, a new diagnosis, barriers to care, homelessness, etc., they are able to make an internal referral for care coordination review. Risk scores are meant to give a quick overview of the patient’s health care needs and level of health care outcome risk. The score will help to determine and monitor progress for care coordination and necessary services.

Justice Involved Individuals

Since the last compliance review, GFHC has formalized a new procedure for care plans with justice-involved individuals upon re-entry to the community. A Care Coordinator is designated to work with ex-offenders and justice-involved members to establish a medical home. The Department of Corrections Care Coordinator is located in the Willimantic office but is available to work with justice-involved members from all sites. The Care Coordinator works with ex-offenders to identify healthcare and social needs, identify goals and develop a care plan to assist the individual in meetings those goals. There are multiple ways a member may be identified as ex-offenders and referred to care coordination through the 2018 patient intake form, the SDoH and Transition Age Youth screener and through providers and the community.

Patient Ping

GFHC recently began utilizing Patient Ping which has enhanced GFHC's ability to identify members who are receiving care at local hospitals for inpatient or emergency care, as well as Skilled Nursing Facilities and Home Care Agencies. Each time a member is admitted, transferred or discharged from any of these facilities, GFHC receives real time notification allowing GFHC staff to contact the member or caregiver to re-direct the member to GFHC if appropriate or schedule a follow-up appointment with GFHC. GFHC has established a protocol to ensure information from Patient Ping reaches the Care Coordinators in a timely manner. Care Coordinators are required to check the care coordination email routinely throughout the day and "Ping" notifications are to be responded to within three hours.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

GFHC reported the most critical success of the program has been the positive impact of care coordination in the lives of their members. GFHC has received positive feedback from the PCMH+ members on how invaluable they find their Care Coordinators, and how they have implemented changes in their care plans which have made their lives easier.

GFHC has connected members to community supports, special needs transportation, previously denied medications, specialists, lab diagnostics, etc., which were previously identified as barriers. GFHC reports that PCMH+ members demonstrate a greatly improved show rate at the health center now as a result of PCMH+ interventions.

Lastly, GFHC's formal adoption of a Care Level Risk Assessment and Care Plan has been cited as a best practice on a state and national level. Recently, Generations was invited to speak at the Centers for Medicare & Medicaid Services forum in Washington, DC on GFHC's practice transformation processes, including the Care Level Risk Assessment and Care Plan.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

GFHC reported experiencing several programmatic challenges; however, the vast majority are outside of the scope of this review and pertain to the larger Medicaid program. These included, but are not limited to the lack of insurance, lack of transportation, lack of family or community supports experienced by members. Other challenges reported included the unwillingness of members to develop a Wellness Recovery Action Plan or psychiatric advanced directive which are described

further below. There was also staff turnover since the last compliance review, which GFHC chose to not fill the vacancies over time and condensed the Behavioral Health Care Coordinator roles into one position.

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

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Program Operations	GFHC is encouraged to include the PCMH+ program and evaluation efforts in future iterations of the quality plan.	GFHC edited the agency's formal quality plan to reference the monitoring and evaluation of PCMH+ program. Monitoring and evaluation is done through the performance improvement reporting grid which reports on metrics such as BH/substance screenings, well-child visits, and PCMH+ risk assessments.	Met
	Evaluate current PCMH+ enhanced care coordination member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities.	As reported in the first quarterly report of 2018, GFHC reports 2,725 (908 per month) unique PCMH+ members received a care coordination or BH care coordination contact during the first quarter of 2018. With an attributed membership of 7,879, that is a penetration rate of 12%. GFHC reported a total of 5,818 care coordination contacts made. With 6.70 FTE Care Coordinators, this calculates to approximately 289 care coordination contacts a month for each Care Coordinator. This is significantly higher than the 31 PCMH+ members with a care coordination contact as of June 2017, which is less than 1% of assigned PCMH+ members (7,465).	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 required to address the recommendations.

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Underservice	Develop an underservice methodology to monitor, prevent, and address underutilization of clinically appropriate services that may be shared with DSS as requested.	As reported in the questionnaire, GFHC does not have a formal methodology for assessing underservice. The oversight committee reviews a report detailing the volume of PCMH+ members and numbers of members terminating with GFHC. Any trends in terminations would be identified and an intervention would occur. GFHC reported in the questionnaire from January 2017 to June 2018, the rate of PCMH+ members actively transferring care out of GFHC went from 4% (272/7,465) to <.1% (9/7,879).	Partially Met
Competencies in Care for Individuals with Disabilities	Continue to work with DSS to refine the definition of members with disabilities.	GFHC reported the current definition of members with disabilities is those who identify themselves as disabled on their intake forms or have been formally deemed disabled by Social Security disability insurance. GFHC utilizes an alternative extended appointments template that identifies if a member needs their appointment adjusted to allow for a sign language interpreter, wheelchair van arrival, or a longer appointment. Counts of members with disabilities and care coordination activities pertaining to their care are monitored in monthly and quarterly reporting. Based on this reporting, GFHC has consistently demonstrated the ability to flag members with disabilities in their electronic medical record and report on the number of members who received an adjusted appointment time during the review period.	Met

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

AREA	OPPORTUNITY	RECOMMENDATION
Underservice	As reported in the questionnaire, GFHC does not have a formal methodology for assessing underservice.	Formalize into a policy the underservice methodology to monitor, prevent, and address underutilization of clinically appropriate services that may be shared with DSS as requested.
Transition Age Youth	GFHC has a process to identify Transition Age Youth on the care level assessment, although not all Transition Age Youth have transition care plans.	Formalize a process to ensure all Transition Age Youth have transition care plans.

RESULTS

The results of the 2018 desk review indicate that GFHC has continued to demonstrate progress or has met the requirements of the recommendations for improvement from 2017. Additionally, GFHC is currently initiating efforts to address 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.

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DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

A. PCMH+ Program Operations Requirements

As the PCMH+ program builds upon PCMH practice requirements, all PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee 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

- Based on the 2017 compliance reviews, it was recommended that GFHC include the PCMH+ program and evaluation efforts in future iterations of the quality plan. GFHC edited the agency's formal quality plan to reference the monitoring and evaluation of PCMH+ program. Monitoring and evaluation is done through the performance improvement reporting grid which reports on metrics such as BH/substance screenings, well-child visits and PCMH+ risk assessments.
- It was also recommended that GFHC evaluate current PCMH+ enhanced care coordinated member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities. As reported in the first quarterly report of 2018, GFHC reports 2,725 (908 per month) unique PCMH+ members received a care coordination or BH care coordination contact during the first quarter of 2018. With an attributed membership of 7,879, that is a penetration rate of 12%. GFHC reported a total of 5,818 care coordination contacts made. With 6.70 FTE Care Coordinators, this calculates to approximately 289 care coordination contacts a month for each Care Coordinator. This is significantly higher than the 31 PCMH+ members with a care coordination contact as of June 2017, which is less than 1% of assigned PCMH+ members (7,465).
- GFHC did not have any other recommendations for improvement in this area. Monitoring of the oversight body requirements 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. GFHC has consistently met these requirements. GFHC has also completed and submitted the PCMH+ report on a timely basis each month and now on a quarterly basis.

- Additionally, GFHC's Board of Directors is comprised of 51% or more of PCMH+ members. The Quality Assurance subcommittee is designated as the oversight body for the PCMH+ program. The Quality Assurance subcommittee discusses ongoing issues, reviews performance data on a quarterly basis, and continues to monitor and evaluate the PCMH+ program. When new policies are created and need approval, they are brought to the Quality Assurance subcommittee for final input and approval.
- Of note, since the last compliance review, GFHC has experienced Care Coordinator turnover including four Care Coordinators in April 2018. As reported in the first quarterly report of 2018, GFHC has a total of 6.70 FTE Care Coordinators (six 1.0 FTE Care Coordinators, one .20 FTE Care Coordinator and one .50 FTE Behavioral Health Care Coordinator). GFHC reported challenges with retention of care coordination staff. As there was staff turnover, GFHC chose to not fill the vacancies over time and combined both the Behavioral Health Care Coordinator roles into one position.

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 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, it was recommended that GFHC develop an underservice methodology which may be shared with DSS as requested. As reported in the questionnaire, GFHC does not have a formal methodology for assessing underservice. The oversight committee reviews a report detailing the volume of PCMH+ members and numbers of members terminating with GFHC. Any trends in terminations would be identified and an intervention would occur. GFHC reported in the questionnaire from January 2017 to June 2018, the rate of PCMH+ members actively transferring care out of GFHC went from 4% (272/7,465) to <.1% (9/7,879).

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.
- 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 results of the 2017 compliance reviews, GFHC did not have any recommendations for improvement in this area. However, counts of members with BH conditions, the number of BH screenings completed, the number of psychiatric advance directives obtained for the member files, the number of Wellness Recovery Action Plan obtained for the member files, the number of Transition Age Youth with transition care plans and the number of interdisciplinary team meetings is monitored through monthly and quarterly reports. GFHC has consistently demonstrated the ability to report on all of these data points with the exception of consistently reporting the number of members with psychiatric advance directives.
- GFHC continues to conduct universal BH screening and utilizes a variety of BH screening tools such as the Patient Health Questionnaire (PHQ)-2/9, the CAGE-AID (a substance use screening), the Columbia Suicide Screening (C-SSRS) the DSM-5 Level 1 Cross-Cutting Symptom Measure – Adult, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), the Pediatric Symptom Checklist and the Modified Checklist for Autism in Toddlers (M-CHAT).
- On the questionnaire, GFHC reported one of the biggest challenges of the program is engaging members in the Wellness Recovery Action Plan planning process. It became standard policy within the BH Department at GFHC that all members who are receiving care coordination services are approached to develop a Wellness Recovery Action Plan, but engagement in the process remains a concern. However, based on the member file review, it was clear that GFHC has developed a clear process to develop and document ongoing progress of Wellness Recovery Action Plans.
- Also on the questionnaire, GFHC reported the other big challenges of the program is obtaining psychiatric advance directives as members have been very resistant to the process. However, based on the member file reviews, GFHC demonstrates a consistent process for inquiring if members have a psychiatric advance directive or wish to develop one. The presence or absence (including declination) of a psychiatric advance directive is clearly documented in each member file.

- For Transition Age Youth, GFHC reported the ability to identify more individuals as Transition Age Youth and utilizes the care level assessment process to identify these members. A more thorough assessment is completed using a Transition Age Youth form that addresses needs such as medical care, dental care, employment services, housing needs, insurance assistance, substance abuse needs, current legal involvement, Department of Child and Family involvement, disability/DSS paperwork needs, transportation needs and social supports, spiritual and cultural needs. However, based on the member file review, it does not appear that all Transition Age Youth have transition care plans.
- Last, GFHC implemented a new monthly integration team meeting format and care plan. The meetings are held at the Putnam and Willimantic sites, where BH care is provided in addition to other care. A provider refers a case for review by the integration team which includes the medical or BH provider, Care Coordinators, Medical Director, BH supervisor, system of care director and others based on the case. During the integration meeting the following areas are reviewed, BH and medical clinical concerns, socioeconomic concerns/barriers including financial, housing, transportation and supports, and the treatment plan. The monthly integration team meetings have consistently including BH care coordination 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 individualized education plan (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 results of the 2017 compliance reviews, GFHC did not have any recommendations for improvement in this area. However, counts of CYSHCN and the documentation of IEPs and 504 Plans is also monitored in monthly and quarterly reporting. Based on this reporting, GFHC has consistently demonstrated the ability to flag CYSHCN in their electronic medical record and report on the number of members with IEPs or 504 Plans in their record.
- GFHC provided clarification for staff regarding how to make referrals to Pediatric Care Coordinators who complete screenings for CYSHCN. In the beginning of 2018, GFHC specified that any pediatric member, including PCMH+ members, who did not complete a dental treatment plan was referred to care coordination for more intensive follow-up.
- Additionally, the review of member files of CYSHCN indicate that GFHC consistently documents efforts to obtain either an IEP or 504 Plan for CYSHCN who have them.

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 GFHC continue to work with DSS to refine the definition of members with disabilities. Per GFHC's response on the questionnaire, GFHC's current definition of disability is those who identify themselves as disabled on their intake forms or have been formally deemed disabled by the Social Security Administration.
- GFHC did not have any additional recommendations 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, GFHC has consistently demonstrated the ability to flag members with disabilities in their electronic medical record and report on the number of members who received an adjusted appointment time during the review period.
- Additionally, GFHC utilizes an alternative extended appointments template that identifies if a member needs their appointment adjusted to allow for a sign language interpreter, wheelchair van arrival or a longer appointment.

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, GFHC did not have any recommendations for improvement in this area. However, staff cultural competency trainings are monitored in monthly and quarterly reporting. Based on this reporting, GFHC has continued to hold cultural competency trainings at least annually with all staff as well as separate onboarding cultural competency training.
- The review of member records demonstrates that although Generations documents and incorporates cultural factors such as race, language and gender identity into member files or the member plan of care, Generations utilizes a gender identity/sexual orientation form with all adult members to gather important information about how a member's gender identify and sexual orientation may impact the provision of health care. The document is also available in Spanish.

COMMUNITY LINKAGES

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, GFHC did not have any recommendations for improvement in this area. However, community linkage requirements are monitored through monthly and quarterly reporting. Based on this reporting, GFHC has continued to maintain a comprehensive list of partnerships with a variety of community-based organizations. These partnerships range across the spectrum of organizations that address the comprehensive needs of PCMH+ members. Since the 2017 compliance review, GFHC has established new community linkages including services for the homeless population, durable medical equipment, therapy, nutrition and BH services. GFHC has also established new linkages with public schools.
- Additionally, the review of member records demonstrates that GFHC completes timely referrals to community resources to address SDoH issues identified under the SDoH assessment. Completion of these referrals and communication with members is clearly indicated under the care coordination care plan.

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:
   A. 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 a Registered Nurse) who reviewed a total of 20 member files.

B. Member File Review Findings

- Care coordination notes are captured in an ongoing care coordination care plan which outlines member goals, progress towards those goals and also the interventions and instructions provided to the member. Care coordination activities are also captured in an ongoing care coordination log.

- Generations utilizes a care level assessment which includes a risk stratification scoring model and an assessment of SDoH. The SDoH assessment is a comprehensive tool and assesses across domains such as home environment, financial stability, access to food, shelter, clothing, healthcare, medications and a phone and childcare.
- Generations screens all members for BH conditions and utilizes screening tools such as the PHQ-2/9, CAGE-AID, C-SSRS, the DSM-5 Level 1 Cross-Cutting Symptom Measure — Adult, WHODAS 2.0, the PDC and M-CHAT.
- PH-BH integration, including BH referrals and assessments, continued to be evident in the files reviewed.
- Generations continues to demonstrate a consistent process for inquiring if members have a psychiatric advance directive or wish to develop one. The presence or absence (including declination) of a psychiatric advance directive is clearly documented in each member file.
- For members with BH conditions, Generations has developed a clear process to develop and document ongoing progress of Wellness Recovery Action Plan. Although it is not clear how members are identified as a member who would benefit for a Wellness Recovery Action Plan.
- For members with BH conditions, Generations develops a BH care plan with clear therapeutic goals. Progress towards these goals is captured in the same care plan. For one member, the member's religious preferences were clearly noted and identified as a protective factor.
- Generations consistently documents the results of the CYSHCN screener in the files of CYSHCN.
- Generations consistently documents efforts obtain either an IEP or 504 Plan for Transition Age Youth and CYSHCN who have them.
- Not all Transition Age Youth have transition care plans.
- Generations continues to document and incorporate cultural factors such as race, language and gender identity into member files or the member plan of care. Generations utilizes a gender identity/sexual orientation form with all adult members to gather important information about how a member's gender identify and sexual orientation may impact the provision of health care. The document is also available in Spanish.
- Generations' member records provide evidence of coordination with other medical providers. For example, one member has a diagnosis of HIV. The member file contained the care plan developed by the Ryan White HIV program and also the results of the quarterly BH screening conducted by the program. This information was incorporated into the member's plan of care.
- Care Coordinators complete timely referrals to community resources to address social determinant of health issues identified under the social determinant of health assessment. Completion of these referrals and communication with members is clearly indicated under the care coordination care plan.

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
Program Operations	The GFHC quality program plan does not include the PCMH+ program or how the PCMH+ program is evaluated or contributes to GFHC's quality goals.	GFHC is encouraged to include the PCMH+ program and evaluation efforts in future iterations of the quality plan.
	Enhanced care coordination member penetration rates are low for the 7,465 assigned PCMH+ membership, but appear to be trending upward. GFHC reports the following monthly care coordination contacts: April 2017: 5 contacts; May 2017: 51 contacts; June 2017: 31 contacts; July 2017: 117 contacts.	Evaluate current PCMH+ enhanced care coordination member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
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.
Competencies in Care for Individuals with Disabilities	GFHC's current definition of disability is limited to those deemed as disabled by the Supplemental Security Income.	Continue to work with DSS to refine the definition of members with disabilities.

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