HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

COMMUNITY HEALTH CENTER

JANUARY 4, 2019

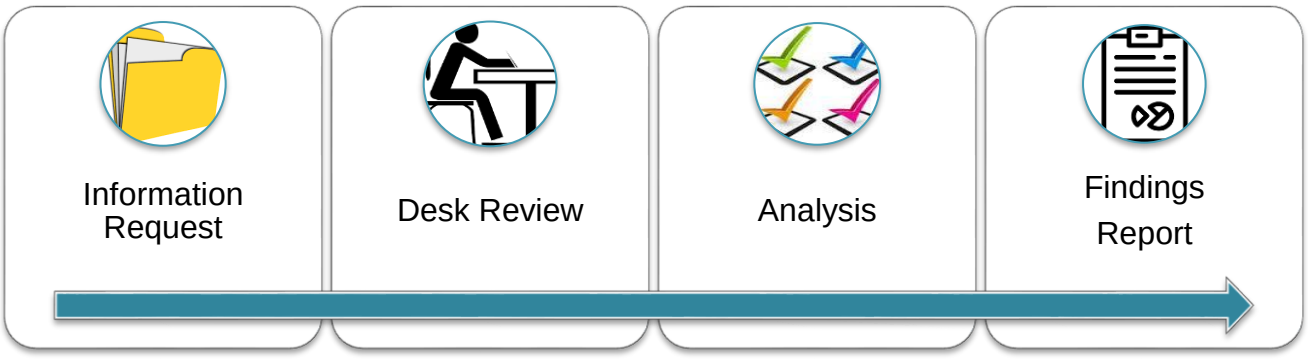
State of Connecticut

CONTENTS

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 Community 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.

2
SUMMARY OF FINDINGS

COMMUNITY HEALTH CENTER PCMH+ PROGRAM OVERVIEW

Community Health Center (CHC) is a Federally Qualified Health Center that provides comprehensive primary care services in medicine, dentistry, and behavioral health (BH), as well as onsite psychiatry, podiatry and chiropractic services throughout the State of Connecticut. CHC has 204 sites located within 14 primary care hubs. CHC also delivers primary care and BH services in 84 school-based health centers (an expansion of 16 sites over the last year), healthcare for the homeless at clinics throughout the State, mobile preventive dental services in nearly 200 schools and Urgent Care Clinics (formally called “Quick Care”) to help ensure members receive timely and effective care and avoid unnecessary emergency room use.

CHC continues to utilize a team-based approach for provide enhanced care coordination activities to 48,580 PCMH+ members attributed in Wave 2 of PCMH+. CHC’s Wave 1 attribution totaled 41,974 members. The PCMH+ team consists of seven FTE Access to Care staff, nine full-time Care Coordinators, four Behavioral Health Care Coordinators, 1.5 FTE dedicated social work coordinators who work specifically with Children and Youth with Special Health Care Needs (CYSHCN) and 45 Registered Nurses (RNs) at multiple sites who devote 25% of their time to provide complex care coordination to PCMH+ members.

CHC has consistently demonstrated a strong penetration rate over the review period. In the first quarterly report for 2018, CHC’s penetration rate was 17%.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

Social Determinants of Health (SDoH)

Since September 2017, CHC has chosen to utilize the Centers for Medicare & Medicaid Services evidence-based SDoH tool for assessing members’ needs. Access to Care staff and complex care RNs utilize the tool with all members assigned to CHC’s Complex Care Management program. Based on the results of the SDoH assessment, care plans, with linked ICD-10 codes, are developed and then documented on the member’s problem list. The care plans include documentation of member-specific goals, interventions and are used to track progress. Access to Care staff also have enhanced roles which include SDoH tracking and resolution. They attend all integrated care meetings, which are almost exclusively focused on PCMH+ members. Integrated care meetings include interdisciplinary team-based discussions addressing medical, BH and psychosocial needs of members (including SDoH). CHC also shared future plans to employ Community Health Workers in at least one of CHC’s communities under the Community and Clinical Integration Program (CCIP), which CHC believes will augment their ability to impact and resolve adverse SDoH.

Patient Ping

CHC established a workflow to ensure information from Patient Ping rapidly reaches the correct team members who will intervene directly with the member. CHC has designated RNs in their triage department responsible for retrieving daily notifications from Patient Ping. These RNs follow specific protocols to engage with the member, conduct medication reconciliation and schedule a primary care visit. CHC also disseminates daily Patient Ping reports to the senior medical assistant at each admitted member's site. This individual alerts the team of the hospital admission to coordinate discharge planning and a post-hospitalization visit. Lastly, CHC reviews emergency room visits to coordinate any necessary follow-up, triage nurses review lists of members who utilized after-hours on-call nurse advice and the triage line to coordinate same-day appointments if needed.

Risk Stratification

CHC has refined the process to identify PCMH+ members with risk scores of seven or higher (per PCMH+ panel reports), those with high numbers of emergency room visits (five in the last 12 months) or a hospitalization within the last 30 days. When these members call CHC, they are flagged by an internally developed application called "NOVO" which results in a direct transfer to a triage nurse. The triage nurse then conducts a brief assessment to assist with appointment scheduling and provide interventions as needed.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

Reduction in Emergency Room Visits

CHC reports a continuous reduction in emergency room visits per 1,000 member months (from 96 to 91 in the last 12 months). CHC attributes this to multiple factors such as an increased availability of same day appointments, an improvement of call management (97% of calls are handled in 30 seconds), the addition of highly-trained after-hour nurse advice and triage service and the triaging of high-risk members flagged "NOVO". CHC has also extended hours of operation on four of seven nights per week at most sites (smaller sites may have extended evening hours only twice per week), is open all day on Saturday at four sites and on Saturday mornings at smaller sites.

CHC's Behavioral Health Care Coordinator also works directly with the primary care nurses and the nurse case manager for each site to address the needs of members who are high utilizers of the emergency room. The Care Coordinator assesses the need for complex care management and individualized nursing visits, provider or BH visits, member education needs and reasons leading to unnecessary emergency room usage.

Integrated Care Meetings

CHC has consistently maintained the requirement to hold integrated care meetings on a monthly basis at each of CHC's 14 primary care sites. The Behavioral Health Care Coordinator plays an important role in these meetings and is responsible for selecting the list of members who will be reviewed at each meeting. This position is also responsible for providing team members with pertinent information about each member ahead of the meetings, ensuring they do not have competing demands that would prevent them from attending the meetings and following up on any action plans developed in the integrated care meetings.

Member Engagement

In mid-April 2017, CHC instructed all CHC Patient Service Advocates and call center staff to obtain email addresses for all members to improve patient portal uptake rate and increase opportunities to engage with members.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

CHC reported experiencing several programmatic challenges; however, the vast majority are outside of the scope of this review and pertain to the larger Medicaid program. Challenges reported included the inability to obtain certain data elements from Patient Ping and obtaining data from CHC to support asthma management. CHC also reported the delay in obtaining a signed PCMH+ contract as a program barrier.

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

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Program Operations	Continue efforts to identify PCMH+ members willing to serve on the PCMH+ Oversight Committee. Ensure there is substantial representation by PCMH+ members as required.	CHC established a Member Advisory Board early in Year 1 of PCMH+. The Board successfully met on a quarterly basis and included 3–4 PCMH+ members at each meeting. In the first quarterly report of 2018, CHC reported that they did not hold a Board meeting due to a lack of quorum. The committee co-chairs are currently working to expand the committee membership to prevent quorum issues from occurring in the future.	Partially 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]
Children and Youth with Special Health Care Needs (CYSHCN)	Develop mechanisms to identify CYSHCN and ensure assessed needs are incorporated in the member's plan of care and accessible to all treating staff.	CHC identifies CYSHCN in the electronic medical records using a formal alert. This allows CYSHCN to be easily identified for further support during a visit or as a member requiring care coordination. CHC has provided consistent reporting of the number of CYSHCN served and related care coordination activities. CHC also documents the needs of CYSHCN clearly in the member's file and this information is available to all team members.	Met
Member File Reviews	Formalize procedures to fully implement the Wellness Recovery Action Plan process for members.	CHC reported some barriers in obtaining copies or completed plans from members. CHC also found the tool chosen (the Wellness Recovery Action Plan Personal Workbook) to be too lengthy for both members and clinicians and is exploring options to reduce the time it takes to complete the tool. However, CHC has consistently reported on the number of members with Wellness Recovery Action Plans and efforts are clearly documented in member files.	Partially Met

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

AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	CHC has not held an oversight committee meeting since March 2018 due to quorum issues.	Develop procedures to ensure PCMH+ member attendance at oversight committee meetings and meet the requirement to hold oversight committee meetings on a quarterly basis at a minimum.
Physical Health/ Behavioral Health (PH-BH) Integration	CHC reports barriers in obtaining, developing and updating Wellness Recovery Action Plans with members.	Continue to develop procedures to obtain, develop and update Wellness Recovery Action Plans with members.
Transition Age Youth	CHC and school-based health center staff have developed a transition care plan template and processes to complete these plans with Transition Age Youth.	Continue to develop procedures to standardize transition care planning with Transition Age Youth in collaboration with school-based health centers.

RESULTS

The results of the 2018 desk review indicate that CHC has continued to demonstrate progress or has met the requirements of the recommendations for improvement from 2017. Additionally, CHC 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.

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

- Based on the 2017 compliance reviews, it was recommended that CHC continue efforts to identify PCMH+ members willing to serve on the PCMH+ Oversight Committee and ensure there is substantial representation by PCMH+ as required. CHC established a Member Advisory Board early in Year 1 of PCMH+. The Board successfully met on a quarterly basis and included 3–4 PCMH+ members at each meeting. In the first quarterly report of 2018, CHC reported that they did not hold a Board meeting due to a lack of quorum. The committee co-chairs are currently working to expand the committee membership to prevent quorum issues from occurring in the future.
- CHC did not have any other recommendations for improvement in this area. Monitoring of 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. CHC has consistently met these requirements. CHC has also completed and submitted the PCMH+ report on a timely basis each month and now on a quarterly basis.

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, CHC did not have any recommendations for improvement in this area. No underservice was noted during the review. CHC had also implemented an underservice prevention policy in June 2017 that supported PCMH+ and CHC broader programs to specifically address potential panel manipulation, evaluate complaints and grievances that could indicate underservice issues, that detailed strict guidelines on member terminations and prohibits rewards to providers for reducing services to members.

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 CHC formalize procedures to fully implement the Wellness Recovery Action Plan process for members. Under the questionnaire, CHC reported some barriers in obtaining copies or completed plans from members. CHC also found the tool chosen to be too lengthy for both members and clinicians and is exploring options to reduce the time it takes to complete the tool.
- Counts of members with Wellness Recovery Action Plans is monitored through monthly and quarterly reporting. CHC has consistently provided the number of members who have Wellness Recovery Action Plans. This count includes obtaining a copy of the plan for the member file.
- The review of member files demonstrated CHC's efforts to develop Wellness Recovery Action Plans with members. Two files included copies of the Wellness Recovery Action Plan Personal Workbook which illustrated the lengthiness of the tool, but also demonstrated CHC's engagement with members to develop their Plans. Another member's file included a Suboxone recovery plan for a member enrolled in a Suboxone treatment program. The use of other recovery planning tools is permitted under the PCMH+ program. The use of this tool provided additional evidence of CHC's efforts to implement this requirement.
- CHC did not have any other 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 Transition Age Youth and those with transition care plans and the number of interdisciplinary team meetings are also monitored through monthly and quarterly reports. CHC 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.
- The review of member files provided evidence that CHC continues to consistently screen members for BH conditions, obtains a copy of psychiatric advance directives for the member file if available and documents if a member opts not to have a psychiatric advance directive.
- CHC BH screening tools include the Patient Health Questionnaire (PHQ) 2/9; 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); Pediatric Symptom Checklist (PSC-17) (identifies psychosocial issues in children); Modified Checklist for Autism in Toddlers (MCHAT) (developmental screening tool for toddlers between 16–30 months of age) and adverse childhood experiences questionnaire (ACES).
- CHC also reported the use of a daily "Clinical Dashboard" which alerts medical assistants about due or overdue screenings, assessments or interventions.
- CHC reported that transition care plans for Transition Age Youth are developed under the Connecticut Children's Medical Center's North Central Medical Home Initiative. These plans have not been accessible through CHC's electronic medical record and CHC has worked with the Medical Center to draft an agreement to share these plans but this has not been successful. CHC is now working with school-based health centers to take the lead in transition care plan development for Transition Age Youth. School-based health center staff have developed a

template to guide transition planning for youth with BH conditions. CHC expects this process to be standardized within the year.

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 CHC develop mechanisms to identify CYSHCN and ensure assessed needs are incorporated in the member's plan of care and accessible to all treating staff. CHC met this requirement by identifying CYSHCN with the electronic medical records using a formal alert. This allows CYSHCN to be easily identified for further support during a visit or as a member requiring care coordination.
- Counts of CYSHCN and the documentation of IEPs and 504 Plans is also monitored in monthly and quarterly reporting. Based on this reporting, CHC 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.
- The review of member files also provided evidence of CHC's progress in this area. Files of CYSHCN indicate that CHC consistently documents information about durable medical equipment and medical supplies, educational needs (including if the member has an IEP or 504 Plan), efforts to obtain the IEP or 504 Plan and care coordination services provided to the member and their family.

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, CHC did not have any 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, CHC 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, review of member records indicate that CHC continues to consistently assess and document the needs of members with disabilities. This includes information regarding durable medical equipment and medical supplies, home health agency information and services and the use of community support services.

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, CHC 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, CHC has continued to hold cultural competency trainings at least annually with all staff as well as a separate onboarding training regarding treating members with disabilities.
- Additionally, the review of member records demonstrates that CHC continues to collect and document cultural needs under member social histories.

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, CHC 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, CHC 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. During the last compliance review, CHC's resource list included over 145 community resources that included organizations providing services such as housing, food assistance, employment, transportation, mental health and addiction, literacy and senior services.
- Member file reviews demonstrated that CHC consistently collects and documents cultural needs and SDoH under the member's social history. Elements include access to food, access to reliable transportation, housing stability, employment status, language/s spoken, religious preferences, member's learning style, member's perception of literacy, identification of sexual orientation, gender identity, preferred pronouns and sex assignment at birth. The information is clearly documented alongside the clinical notes and available to all team members in the electronic medical record.

MEMBER FILE REVIEWS

A. Member File Review Process

PEs were instructed to provide the following 20 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 Plan 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 17 member files.

B. Member File Review Findings

- CHC member files continued to include evidence of care coordination for members, including well documented follow up by the care coordinator, internal coordination among team members (including the BH care coordinator if applicable), referrals and subsequent access to the necessary services and supports.
- CHC continues to provided evidence of consistent screening of members for BH conditions.
- There continued to be consistent evidence of obtaining the psychiatric advance directive for the member file. If the member does not want a psychiatric advance directive, CHC notes this in the member record.
- CHC is still developing procedures to fully implement Wellness Recovery Action Plans with members. However, for one member enrolled in a Suboxone treatment program, the team developed a Suboxone recovery plan as part of the treatment planning process. For other members, the team utilized a Wellness Recovery Action Plan Personal Workbook to develop the member's Wellness Recovery Action Plan.

- Information pertaining to CYSHCN continues to be evident. Information collected includes durable medical equipment and medical supplies, school information and whether an IEP or 504 Plan exists, and care coordination needs of the child and family. It is also clear CHC is actively working to obtain copies of the IEP or 504 Plan.
- There was consistent evidence that members with disabilities are assessed. Information collected includes durable medical equipment and medical supplies, home health agency information and services and use of community support services.
- CHC continues to collect and document cultural needs and SDoH under the member's social history. Information collected includes SDoH (e.g., access to food, access to reliable transportation, housing stability, employment status), language(s) spoken, religious preferences, member's learning style, member's perception of literacy, identification of sexual orientation, gender identity, preferred pronouns and sex assignment at birth. The information is documented alongside the clinical notes.

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	There has been limited member representation/ongoing participation in the PCMH+ Oversight Committee. CHC indicates one PCMH+ member is currently participating, but are taking active steps to identify additional PCMH+ members and encourage broader participation.	Continue efforts to identify PCMH+ members willing to serve on the PCMH+ Oversight Committee. Ensure there is substantial representation by PCMH+ members as required.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
CYSHCN	CHC indicates a process to identify Children with Special Health Care Needs, but this process was informal and generally documented on paper and not incorporated into the electronic medical record. Identified this as an opportunity area to incorporate tracking and documentation methods within the electronic medical record for continuity of care and reporting.	Develop mechanisms to identify Children with Special Health Care Needs and ensure assessed needs are incorporated in the member's plan of care and accessible to all treating staff.
Member File Reviews	CHC is still developing procedures to fully implement Wellness Recovery Action Plan with members.	Formalize procedures to fully implement the Wellness Recovery Action Plan process for members.

MERCER (US) INC.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer.com