HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

CORNELL SCOTT-HILL HEALTH CENTER

JANUARY 4, 2019

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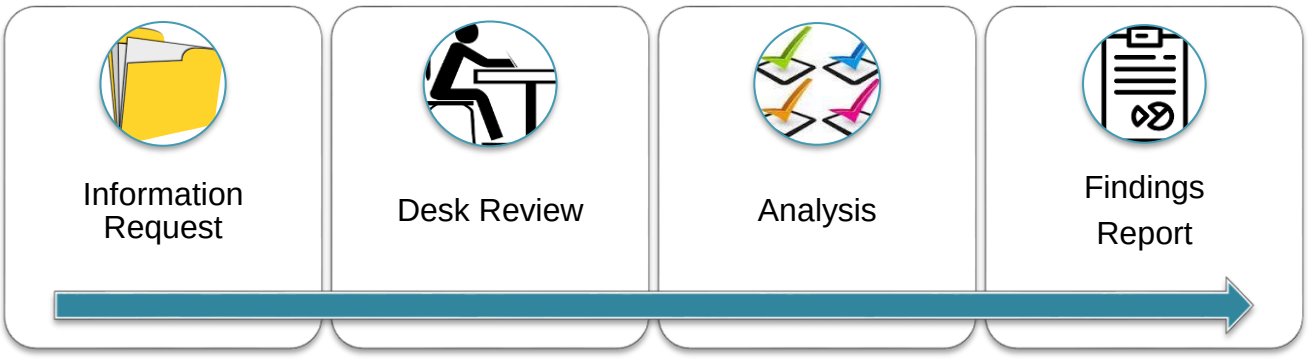
INTRODUCTION

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 Cornell Scott-Hill 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

CORNELL SCOTT-HILL HEALTH CENTER PCMH+ PROGRAM OVERVIEW

Cornell Scott-Hill Health Center (CS-HHC) is a Federally Qualified Health Center established in 1968. In collaboration with the community and the Yale School of Medicine, CS-HHC provides its members with an array of primary care and specialist care, including audiology, behavioral health (BH), cardiology, dental, dermatology, ear, nose and throat, gastroenterology, geriatrics, infectious diseases, internal medicine, OB/GYN, orthopedics, podiatry, rheumatology, urology, and vision services through its 19 locations throughout New Haven County. In addition, CS-HHC operates five school-based health centers in New Haven, a 24-hour inpatient detox unit, partner care sites at the Connecticut Mental Health Center and Gateway Community College.

CS-HHC continues to utilize a care team (pod) approach to provide enhanced care coordination activities to 13,750 PCMH+ members (Wave 1 attribution totaled 12,979 members). The PCMH+ team consists of six full-time Care Coordinators, one full-time Behavioral Health Care Coordinator, two Nurse Care Management Coordinators, one full-time Director of Care Coordination and one full-time Assistant Manager of Care Coordination. The Behavioral Health Care Coordinator works to support PCMH+ members at all of CS-HHC's locations. New for Wave 2, CS-HHC has assigned one designated Care Coordinator to each clinical site versus having multiple Care Coordinators assigned to some of the same sites. In the largest clinical site two Care Coordinators are assigned to engage members due to the large PCMH+ population.

CS-HHC has consistently demonstrated an average penetration rate of 2% over the review period. In the first quarterly report for 2018, CS-HHC's penetration rate was 2%.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

Care Coordination

Since September 2017, CS-HHC has continued to develop its PCMH+ program with an emphasis on fostering the training and expansion of their care coordination team. CS-HHC has implemented standardized protocols, better integrated their Care Coordinators into onsite care teams, and increased the deployment of additional tools for care coordination services to their members. The development of the care coordination team included an expansion of the team from eight staff members to 11. This expansion enabled CS-HHC to dedicate a full-time Care Coordinator to each of their primary care sites which are located in New Haven (4), West Haven (1), and Ansonia (1). CS-HHC has brought their integrated care team meetings to their main care site on Columbus Avenue in New Haven so that their Care Coordinators may now participate. These integrated team meetings, hosted by the primary care clinician each week include a regular review of the member's care needs. In addition to these new staff members, CS-HHC has added a new role, a Nurse Care Management Coordinator. CS-HHC has hired two Licensed Practical Nurses to staff these roles,

thus improving the capacity to address higher level, more complex member needs, especially for those patients that are medically complex.

Wellness Recovery Action Plans

CS-HHC has implemented new standardized protocols with their care coordination teams. These included a new approach to delivering Wellness Recovery Action Plans. The first part of the Wellness Recovery Action Plan consists of a social determinants of health (SDoH) screening that is given to all members. This screening serves as a trigger for the completion of a larger Wellness Recovery Action Plan, if needed. CS-HHC has also added a new pediatric Wellness Recovery Action Plan to use with their younger members.

Technology

CS-HHC has deployed additional care coordination tools including the use of Patient Ping at their Ansonia care site. CS-HHC continues to use systems developed with Yale New Haven Hospital to efficiently identify patients who enter the emergency department. These tools have improved the ability to coordinate timely, post-acute care. CS-HHC continues to plan for the Epic® platform launch in April of 2019 as well as the addition of the Project Notify tool, which is an alert system that notifies providers when a Medicaid member is either discharged or admitted into a hospital facility. CS-HHC has also continued to develop their clinical dashboard which integrates data from CareAnalyzer and their electronic medical record data to provide guidance to each of their clinical providers.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

CS-HHC program successes include increased provider adoption and engagement across all of their care sites, increased patient engagement across the population, and improved and enhanced access to post-acute discharge care coordination. CS-HHC states that their providers now routinely seek out the support of their assigned, onsite Care Coordinator(s) as they identify and recognize in real time their members' care coordination needs and the opportunity to have those needs addressed immediately. CS-HHC members are now actively recognizing and welcoming their Care Coordinators as part of the care team. Members are reaching out to their Care Coordinators with eagerness for assistance with addressing issues that arise. CS-HHC's patient satisfaction surveys capture their patients' expressions of gratitude for this assistance as well as the significant impact the Care Coordinators have had in their lives.

During CS-HHC's provider meetings, providers are acknowledging the value of the PCMH+ program and the value of having daily access to the Care Coordinators which has increased member engagement and follow through with treatment plans. Some of the positive program attributes recognized by providers are having a greater sense of awareness of their members' care paths, having a new awareness of their members' engagement within post-acute settings and post-acute discharge coordination, having a greater sense of control and support for their members and being able to affect member care outcomes.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

CS-HHC reported experiencing several programmatic challenges; however, the vast majority of challenges experienced are outside of the scope of this review and many pertain to the larger Medicaid program. Challenges reported included the inability to obtain sufficient space for new staff, the ability to provide secure and private telephone access between members and staff who are working remotely, limited quality measures available in CareAnalyzer, and the inability to obtain certain data pertaining to BH and HIV/AIDS. CS-HHC 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	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.	CS-HHC had increased their penetration rates month over month up to 3.2% through October 2017. Then the average penetration rate dropped to 1.7% from November 2017 through March 2018. CS-HHC did report that there was staff turnover during Wave 1. On the April–June quarterly report, CS-HHC reported a penetration rate of 2% which is an increase from last quarter's reporting. PE reports a total of 1,224 (408 per month) care coordination contacts made during the reporting timeframe. With nine Care Coordinators, this calculates to approximately 45 care coordination contacts a month for each Care Coordinator.	Met
	Include the PCMH+ program and evaluation efforts in future iterations of the quality plan.	CS-HHC has updated their quality plan to reflect the PCMH+ initiative. This quality plan was approved by CS-HHC's Board of Directors and is integrated into their larger Quality Assurance/Quality Improvement program.	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]
Member File Reviews	Consider adoption of a standardized social determinants of health tool that identifies social determinants of health needs of members.	CS-HHC has adopted a standardized social determinants of health tool which is used by Care Coordinators with all PCMH+ members. This tool includes employment, income and benefit status, family and social system support system, transportation needs, housing and utility needs, interpersonal safety and legal issues. The results of the assessment are available to all team members in the electronic medical record.	Met

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

AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	CS-HHC reports holding three oversight committee meetings for the first quarterly report with only one PCMH+ voting member in attendance. This is similar to the CS-HHC's Year 1 reporting.	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the oversight committee meetings such that CS-HHC demonstrates compliance with the "substantial representation" requirement within PCMH+.
Physical Health-Behavioral Health (PH-BH) Integration	CS-HHC reports they are not able to report counts of Transition Age Youth with transition care plans on the monthly/quarterly reports at this time. However, CS-HHC does engage in transition planning.	Formalize procedures to report counts of Transition Age Youth with transition care plans on quarterly reports.

RESULTS

The results of the 2018 desk review indicate that CS-HHC has continued to demonstrate progress or has met the requirement in the recommendations for improvement from 2017. Additionally, CS-HHC 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 CS-HHC continue efforts to evaluate current PCMH+ enhanced care coordination member penetration rates and develop a process to increase the number of PCMH+ members engaged in care coordination activities. CS-HHC has developed and instituted a productivity standard for Care Coordinators which states they should demonstrate 30 contacts per week for outreach and engagement with their members. CS-HHC incorporates their program evaluation efforts into their quality plan. CS-HHC has also adopted a standardized SDoH tool which is used by Care Coordinators with all PCMH+ members.
- CS-HHC did not have any other recommendations for improvement in this area. However, based on monthly and quarterly reporting, CS-HHC has not met the requirement to have substantial representation of PCMH+ members on their Member Advisory Board. CS-HHC established a Member Advisory Board early in Year 1 of PCMH+ and the Board met successfully on a quarterly basis and monthly during April, May and June 2018. Each meeting included only one to two PCMH+ members at each meeting and only one PCMH+ member at the April, May and June 2018 meetings.
- CS-HHC 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. CS-HHC has consistently met these requirements. CS-HHC 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, CS-HHC did not have any recommendations for improvement in this area. No underservice was noted during the review. CS-HHC has added a formalized process to evaluate for underservice. CS-HHC's care coordination leadership randomly selects a set number of PCMH+ members' files for the medical director of Quality and Operations to review and distribute to the appropriate medical directors. The medical directors are instructed to review charts in order to identify any gaps in care, defined as any indicated diagnostic testing, referrals, or medical therapies that had not been provided. Once the chart reviews have been completed the results are sent for compilation and discussed with leadership. The latest review found no evidence of underservice of PCMH+ 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

- CS-HHC did not have any recommendations for improvement in this area; however, counts of members with BH conditions, the number BH screenings completed, counts of members with Wellness Recovery Action Plans, counts of Transition Age Youth with transition care plans and the number of interdisciplinary team meetings held is monitored through monthly and quarterly reporting. CS-HHC has consistently demonstrated the ability to report on all of these measures; though, since the onset of PCMH+, CS-HHC has not reported on the number of psychiatric advance directives obtained for the member files or the number of Transition Age Youth with transition care plans. Although, it is important to note that member files indicate that overwhelmingly, members decline a psychiatric advance directive. CS-HHC does consistently inquire about the presence of a psychiatric advance directive.
- CS-HHC continues to conduct universal BH screening and utilizes a variety of BH screening tools including; the Patient Health Questionnaire (PHQ) 2/9 to screen for depression and the CAGE-AID (a substance use screening tool) and the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST) 3.0.
- For members with BH conditions, the electronic medical record continues to show integration of PH-BH. It was evident in the files that both PH and BH notes were available for review and management of members' health care needs.
- Last, CS-HHC continues to have a process in place to develop and update Wellness Recovery Action Plans. The plans are available to any member, not just those with BH needs. The plans are comprehensive and include member goals, objectives, dates to achieve, recovery plan/triggers/action plan, and community supports were collected and are accessible through the electronic medical record to all treating providers. Similarly, for Transition Age Youth, CS-HHC has added transition-related questions to their comprehensive assessment. If transition goals are identified in the assessment, they are evident in the Wellness Recovery Action Plan.

A. CYSHCN Requirements

Children and Youth with Special Health Care Needs (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, CS-HHC did not have any recommendations for improvement in this area. However, counts of CYSHCN members and care coordination activities pertaining to their care are monitored in monthly and quarterly

reporting. Based on this reporting, CS-HHC 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 CS-HHC's progress in this area. CS-HHC has added school-related questions to the comprehensive assessment. The questions include inquiring about the presence of an IEP or 504 Plan and if the child's special needs impacts school attendance or performance. When available, CS-HHC places a copy of the IEP or 504 Plan in the member file. For one CYSHCN, the Care Coordinator even attended a school meeting to assist the family with education-related care coordination.

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, CS-HHC 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, CS-HHC 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.

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 social determinants of health and community resource needs. The following are PCMH+ program Cultural Competency requirements:

- Conducting annual cultural competency training that includes methods to address the needs of members with disabilities for all practice staff.
- Expanding the individual care plan to include an assessment of the impact culture has on health outcomes.

- Integrating culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

B. Cultural Competency Findings

- Based on the results of the 2017 compliance reviews, CS-HHC 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, CS-HHC has continued to hold cultural competency trainings at least annually with all staff as well as a separate onboarding training for new staff.
- For Wave 2, CS-HHC has implemented a new online self-guided cultural competency training tool which encompasses topics such as awareness of self, generating awareness about the world around us, recognizing norms and values, acknowledging differences, effective communication skills, building rapport, giving feedback, respectful behaviors, handling sensitive situations as well as walk-thru case studies.
- Additionally, the review of member records demonstrates that CS-HHC continues to collect and document cultural needs in the member's electronic medical record.

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, CS-HHC 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, CS-HHC 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, CS-HHC's resource list included over 47 community resources that included organizations providing services such as housing, food assistance, employment, transportation, mental health and addiction, literacy and senior services.
- Additionally, CS-HHC has expanded their comprehensive assessment to include SDoH such as employment, income and benefit status, family and social system support system, transportation needs, housing and utility needs, interpersonal safety and legal issues. This assessment is given to all members. The results of the assessment are available to all team members in the electronic medical record.
- The review of member files provided evidence that CS-HHC enrolls members in their Complex Care Management program where Care Coordinators conduct comprehensive assessments that

address PH-BH needs (in addition to other needs). The tool is available in both English and Spanish.

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 social determinants of health 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 social determinants of health.
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 social determinants of health 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 a Registered Nurse) who reviewed a total of 20 member files.

B. Member File Review Findings

- CS-HHC enrolls members in their Complex Care Management program where Care Coordinators conduct comprehensive assessments that address communication, health literacy, digital literacy, PH and BH needs. The tool is available in both English and Spanish. Since the last compliance review, this assessment has been expanded to include SDoH such as employment, income and benefit status, family and social system support system, transportation needs, housing and utility needs, interpersonal safety and legal issues. The results of the assessment are available to all team members in the electronic medical record.
- Care Coordinators document ongoing efforts to engage with members who no-show for appointments or do not follow-up with the Care Coordinator.
- For members with BH conditions, the electronic medical record continues to show integration of PH-BH needs. It was evident in the files that both PH and BH notes were available for review and management of members' health care needs.
- Additionally, for members with BH conditions, CS-HHC consistently inquires about the presence of a psychiatric advance directive. However, overwhelmingly, members decline having a psychiatric advance directive.
- There is evidence of universal BH screenings. CS-HHC utilizes screening tools such as PHQ-2, PHQ-9, CAGE-AID and WHO-ASSIST 3.0.
- CS-HHC has a process in place to develop and update Wellness Recovery Action Plans. The plans are available to any member, not just those with BH needs. The plans are comprehensive and include member goals, objectives, dates to achieve, recovery plan/triggers/action plan, and community supports were collected and are accessible through the electronic medical record to all treating providers.
- For Transition Age Youth, CS-HHC has added transition-related questions to the comprehensive assessment. If transition goals are identified in the assessment, they are evident in the wellness recovery action plan.
- Care Coordinators are available to conduct home visits and meet members in the community when needed. For one CYSHCN, the Care Coordinator even attended a school meeting to assist the family with education-related care coordination.
- For CYSHCN, CS-HHC has added school-related questions to the comprehensive assessment. The questions include inquiring about the presence of an IEP or 504 Plan and if the child's special needs impacts school attendance or performance. When available, CS-HHC places a copy of the IEP or 504 Plan in the member file.
- Cultural preferences and needs continue to be clearly documented in the medical record. CS-HHC collects information on race, ethnicity, preferred language and religious beliefs. CS-HHC also inquires if the individual identifies as transgender.

- Care Coordinators document member interactions in the electronic medical record and these notes are available to all team members. The notes are detailed and contain evidence of referrals to community resources.

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	Enhanced care coordination member penetration rates are low for the 12,979 assigned PCMH+ membership, but appear to be trending upward. CS-HHC reports the following monthly care coordination contacts: April 2017: 110 contacts; May 2017: 273 contacts; June 2017: 303 contacts; July 2017: 337 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.
	CS-HHC's quality program description does not include the PCMH+ program or how the PCMH+ program is evaluated and contributes to CS-HHC's quality goals.	Include the PCMH+ program and evaluation efforts in future iterations of the quality plan.
Member File Reviews	CS-HHC does not have a distinct social determinants of health screening tool or intervention summary.	Consider adoption of a standardized social determinants of health tool that identifies social determinants of health needs of members.

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