HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

FAIR HAVEN COMMUNITY HEALTH CARE

JANUARY 4, 2019

State of Connecticut

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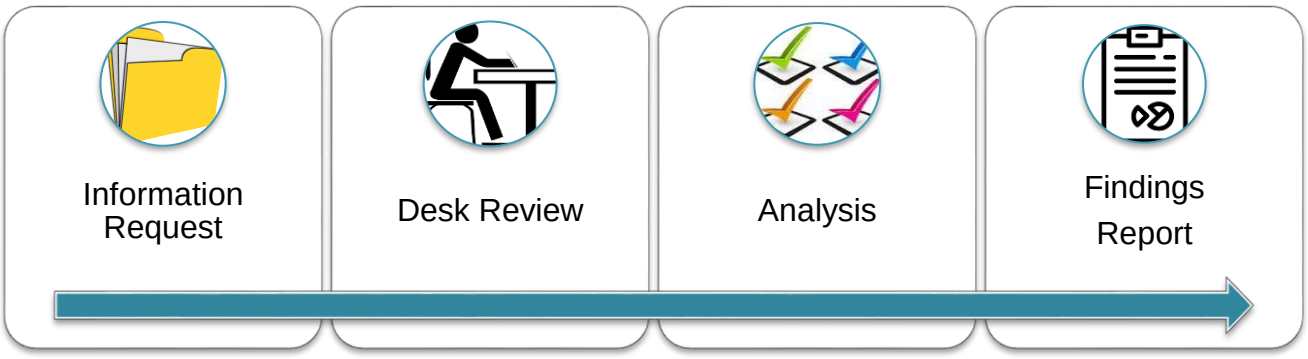
INTRODUCTION

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 robust nature of the Wave 1 compliance review, as well as the ongoing monthly and quarterly monitoring of the PEs, it was determined that Legacy PEs would undergo 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 Fair Haven Community HealthCare 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

FAIR HAVEN COMMUNITY HEALTH CARE PCMH+ PROGRAM OVERVIEW

Fair Haven Community Health Care (FHCHC) is a Federally Qualified Health Center serving New Haven, Connecticut. FHCHC provides an array of primary care and specialist care to its members including behavioral health (BH), medication assisted therapy (MAT), dental, infectious disease, midwifery and women's health and pediatric and well-child services. Additional services include a mobile dental clinic, five school-based health centers, social services and a Women, Infant and Children's (WIC) program. FHCHC also offers extended weekday office hours until 7:00 pm.

Under PCMH+, FHCHC continues to utilize a team based approach to serve 8,075 PCMH+ members (Wave 1 attribution totaled 7,383 members). Staffing for PCMH+ includes eight full time Care Coordinators and two full time Behavioral Health Care Coordinators. There was a vacancy for a Behavioral Health Care Coordinator position in January 2018 but full staffing resumed by the second quarter of 2018.

FHCHC reported a penetration rate of 5.3% in the second quarterly report. This is an increase over the past year when the penetration rates ranged from a low of 2.2% to a high of 4.4% in 2017. Based on the staffing allocation, each Care Coordinator averages approximately 41 care coordination contacts per month.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

Social Determinants of Health (SDoH)

FHCHC has ingrained screening for SDoH into the workflow for high risk and high utilizing members. FHCHC uses a validated, evidence-based screening tool to assess SDoH elements including; transportation needs, housing, safety and violence, educational background, employment status, finances, food security and support systems. FHCHC has established an ambulatory intensive care unit clinic where Care Coordinators screen all appropriate members when they arrive for an appointment after an emergency room visit or hospital admission. All positive SDoH screening questions are added to the problem list in the medical record so that social determinants are a part of the permanent medical record and are included as part of the overall risk and complexity determination.

Programs for Specialty Populations

FHCHC has implemented new clinical and quality improvement programs to support specific populations such as members who are at high risk or have high utilization of services, members with asthma, diabetes, severe and persistent mental illness (SPMI) and complex pediatric BH needs. The asthma clinic is staffed by a board certified asthma and allergy specialist, an asthma educator

nurse and a Care Coordinator. All members are comprehensively evaluated, tested and treated, are screened for SDoH and have an asthma action plan created.

The Developmental and Behavioral Pediatrics Clinic is based in the East Haven site which was chosen because the physical environment is quieter and better suited to treating a population with a high percentage of children with autism spectrum disorder diagnoses. The clinic is staffed with a psychologist and pediatrician with expertise in developmental pediatrics. Children and caregivers participate in the development of a comprehensive, interdisciplinary treatment plan and all families are screened for SDoH. Accommodations such as longer appointment times are offered for complex cases. Reporting capabilities continue to evolve to support ongoing quality improvement efforts and implementation of all population health programs.

Focus on Quality

FHCHC's PCMH+ program has expanded to include a focus on high value, high quality care delivered by care teams supported by robust, standardized, measurable care coordination activities available at all sites. New workflows have been developed to support the FHCHC's quadruple aim of improved quality, decreased cost, improved patient satisfaction and improved provider satisfaction. All care coordination encounters are documented the same way in the electronic medical record, Epic®, templates have been standardized and the physical health-behavioral health (PH-BH) referral process has been improved for greater ease.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

Appropriate Service Utilization

FHCHC reports an improvement in post-hospital follow up within seven days increasing from 25% to 50% and emergency room high utilization showing a reduction from 30% to 18%. FHCHC attributes these improvements to their ambulatory intensive care unit clinic efforts. At each encounter, members are seen by a medical provider, a mental health provider with additional screening done and a Care Coordinator. SDoH are assessed and members are connected to internal or community-based services as needed.

Member Engagement

FHCHC has Care Coordinators located across four sites and there is a dedicated Care Coordinator for triage available to all 13 sites. FHCHC reports this has resulted in an increase in care coordination contacts. FHCHC utilizes huddle reports which are reviewed daily and prompt the teams to look at quality metrics and gap analyses for all members scheduled that day. In July 2018, specific reports were created which prompt for routine metrics such as a depression and substance use screening and a reminder to engage members with diagnoses of schizophrenia, bipolar disorder or severe major depression in discussions about completing Wellness Recovery Action Plans or Psychiatric Advance Directives.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

FHCHC reported the majority of their challenges come from the limited measurement capabilities related to their electronic medical record, Epic® system. Epic® is not capable of measuring specific measures needed for the PCMH+ and the surrogate measures FHCHC has tried to develop do not accurately capture the intended measurement.

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

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Program Operations	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.	FHCHC's penetration rate has increased to 5.3% as of June 2018. There were 429 unique members with a contact and a total of 1,219 contacts made per the second quarterly report compared to 650 total contacts in the first three months of 2018. FHCHC indicates that the screening for SDoH has been one of the contributing factors to the increase in contact.	Met
Underservice	Develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.	FHCHC reports that they compare preventive and chronic disease quality metrics of their PCMH+ members against the overall population and find no difference. Examples included rates for colorectal cancer screening, hypertension control, diabetes control, cervical cancer screening and medication management for people with persistent asthma.	Partially Met
PH-BH Integration	Finalize the Wellness Recovery Action Plan process and ensure that for members who would benefit, that a Wellness Recovery Action Plan or other recovery action plan is developed in collaboration with the member and family.	All members diagnosed with severe major depression, schizophrenia or bipolar disorder are eligible for a Wellness Recovery Action Plan. The BH department huddle also identifies members with these diagnoses who do not have a Wellness Recovery Action Plan yet. The electronic medical record has been updated to track and measure Wellness Recovery Action Plan identification and completion.	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	Formalize procedures to ask members if they have a psychiatric advance directive and methods to document the presence of a psychiatric advance directive in the member file.	The BH huddle report for members with serious persistent mental illness prompts the inquiry of the presence of a psychiatric advance directive, and the information can be tracked in the electronic medical record.	Met
	Formalize procedures to identify members who would benefit from Wellness Recovery Action Plan and the process to develop Wellness Recovery Action Plans with those members.	The BH huddle report for members with serious persistent mental illness prompts the Care Coordinator to identify members who are appropriate for developing a Wellness Recovery Action Plan. The information can be tracked in the electronic medical record.	Met

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

AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	FHCHC had not held an oversight committee meeting since December 2017.	Formalize procedures to ensure PCMH+ member attendance at oversight committee meetings and meet the requirement to hold oversight committee meetings on a quarterly basis at minimum.
Underservice	FHCHC is only evaluating underservice by comparing quality metrics of PCMH+ members against the overall population.	FHCHC provided monitoring examples but the methodology appears to be incomplete. FHCHC should refer to the underservice utilization monitoring strategy and the five pronged approach to develop a comprehensive strategy to identify potential under service utilization or inappropriate reductions in access to medically necessary care.

RESULTS

The results of the 2018 desk review indicate that FHCHC has continued to demonstrate progress or has met the requirements of the recommendations for improvement from 2017. Additionally, FHCHC 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 review, it was recommended that FHCHC evaluate the current PCMH+ enhanced care coordination member penetration rate and develop a process to increase the number of members engaged in care coordination activities. After review of the quarterly and monthly reports, FHCHC reports a penetration rate of 5.3% and contacts have increased significantly.
- Although not noted as a recommendation for improvement from the 2017 compliance review, FHCHC did not appear to be holding regular advisory meetings in 2018. FHCHC held Advisory Board Meetings in March, July, October and December 2017. There were four PCMH+ member attendees in March, seven in July, 11 in October and four in December. FHCHC distributes flyers to inform members of the meetings.
- FHCHC 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. FHCHC has consistently met these requirements. FHCHC 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, it was recommended that FHCHC develop a methodology to monitor, prevent and address underutilization. FHCHC provided monitoring examples but the methodology appears to be incomplete. No underservice was noted during the review.

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 FHCHC formalize procedures to fully implement the Wellness Recovery Action Plan process for members. Under the questionnaire, FHCHC reported that they identify members with diagnoses of severe major depression, schizophrenia or bipolar disorder as eligible for a Wellness Recovery Action Plan and include this information on the huddle report reviewed weekly in BH. The BH department huddle also identifies members with these diagnoses who do not have a Wellness Recovery

Action Plan yet. Last, the electronic medical record has been updated to track and measure Wellness Recovery Action Plan identification and completion. The review of member files supported FHCHC's efforts to develop Wellness Recovery Action Plans with members. Although, counts of members with Wellness Recovery Action Plans is monitored through monthly and quarterly reporting. While FHCHC has consistently provided the number of members who have Wellness Recovery Action Plans, the numbers appear low in some reporting periods. The second quarterly report indicates that zero Wellness Recovery Action Plans were obtained and a copy maintained in the record and ort and three Wellness Recovery Action Plans were developed or updated during the reporting timeframe.

- FHCHC did not have any other recommendations for improvement in this area; however, counts of members with BH conditions, the number of members screened for BH conditions, the number of psychiatric advance directives obtained for the member files, counts of transition age youth and those with transition care plans and the number of interdisciplinary team meetings held is monitored through monthly and quarterly reporting. FHCHC 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 indicate that FHCHC continues to conduct universal BH screening with members. FHCHC utilizes an array of BH screening tools such as 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); the Generalized Anxiety Disorder (GAD)-7, and the CRAFFT screening for adolescent substance use.
- The review of member files also provided evidence that FHCHC continues to 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.
- To assist with management of patient care, FHCHC reported the use of huddle reports which alert Care Coordinators about due or overdue screenings, assessments or interventions. The BH huddle reports specifically prompt for the presence of psychiatric advance directive or identify members appropriate for a Wellness Recovery Action Plan.
- The reviews of member files also show that FHCHC has developed a care plan for transition age youth that is included in the clinical notes. The care plan is utilized during annual physical exams, starting at the 15-year visit, and provides prompts to the physician to engage the member and the family in a transition discussion. In the first quarterly report of 2018, 129 Transition Age Youth transition care plans were developed or updated.
- Lastly, FHCHC holds weekly integrated team meetings including medical, BH, operations, care coordination and administrative staff. Specific cases are discussed among the team members. A Care Coordinator with substance use disorder expertise also attends a weekly city-wide meeting with partner agencies to discuss the complex care needs of the PCMH+ population.

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

- FHCHC 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, FHCHC has consistently demonstrated the ability to flag CYSHCN in their electronic medical record. FHCHC reports they do not have a way to document IEPs or 504 Plans within the electronic medical record in a way that allows for this reporting. This is documented individually on children receiving care coordination services.
- The member file reviews supported FHCHC's efforts for CYSHCN. FHCHC utilizes a care coordination tool that addresses needs in the school environment, requests contact information for the school and attempts to obtain the IEP or 504 Plan, assesses SDoH, BH needs, need for durable medical equipment and home health supplies, other medical or care coordination services and provides a follow up plan for future care and appointments.

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, FHCHC 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, FHCHC has consistently demonstrated the ability to flag members with disabilities in their electronic medical record. FHCHC is unable to track adjusted appointment times; however, according to the second quarterly report members who require additional time are accommodated.
- Additionally, review of member records indicate that FHCHC continues to consistently assess and document the needs of members with disabilities. The care coordination assessment assesses the need for adaptive supports to maximize independence in the community (such as durable medical equipment).

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, FHCHC 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, FHCHC has held an annual cultural competency training as required. The most recent training in January 2018 included 195 practice staff.
- Additionally, the review of member records demonstrates that FHCHC continues to collect and document preferred languages, ethnic group and religious or spiritual beliefs for members with BH needs on the BH assessment.

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, FHCHC 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, FHCHC has an abundance of established community linkages with a variety of community-based organizations to meet the comprehensive needs of PCMH+ members. These partnerships range across the spectrum of organizations that address the comprehensive needs of PCMH+ members. During the last compliance review, FHCHC's list included organizations that assist members with employment, mental health and addiction, legal issues, child serving and senior matters. Other relations include providers of legal immigration services, as well as programs to help members who are formerly incarcerated, transgendered or living with HIV.
- Evidence of referrals for community resources and member interactions are clearly documented in the care coordination assessment tool, care coordination and clinical notes which are accessible to all team members.

MEMBER FILE REVIEWS

A. Member File Review Process

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

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

Mercer asked that files include:

1. A demographic description or demographic page which should include at a minimum: member name, member ID, date of birth, gender and preferred language.
2. The most recent member assessment, including an assessment of SDoH.
3. Most recent plan of care. If assessed cultural needs and preferences are located elsewhere in the member file, copies of this documentation may be provided in addition to the plan of care.
4. Care coordination progress notes, including, but not limited to, referrals to community resource agencies that address SDoH for the specified timeframe. Please note this does not include physician progress notes.
5. Results of most recent BH screening(s).
6. Advance care directive for members with BH conditions (if applicable to the member). If declined by the member, progress notes or other evidence may be provided showing the PE's efforts.
7. Copy of Wellness Recovery Action 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 16 member files.

B. Member File Review Findings

- FHCHC member files included evidence of a care coordination assessment tool that gathers key information about member medical and BH needs as well as a comprehensive assessment of SDoH. SDoH elements include; transportation needs, housing, safety and violence, educational background, employment status, finances, food security and support systems. The assessment tool is adaptable to for certain populations. For example, for members with disabilities, the assessment queries the need for adaptive supports to maximize independence in the community (such as durable medical equipment). For pediatric members, the tool asks questions about early childhood and early intervention services, special education needs and child welfare involvement. FHCHC also utilizes a separate tool to assess solely for SDoH.
- There was evidence of consistent screening for BH conditions. FHCHC utilizes screening tools such as the PHQ-2/9, GAD-7, CRAFFT and SBIRT.
- FHCHC has implemented a process to consistently ask members with BH conditions if they have a psychiatric advance directive or would like to develop one.

- FHCHC has developed a Wellness Recovery Action Plan process and documents discussions with members about the benefits of a Plan. Evidence of Wellness Recovery Action Plans was available in member files.
- FHCHC has developed a care plan for transition age youth which is incorporated into the clinical notes. The care plan is utilized during annual physical exams, starting at the 15-year visit, and provides prompts to the physician to engage the member and family in a transition discussion.
- FHCHC continues to utilize the care coordination assessment tool for CYSHCN through a comprehensive care coordination assessment tool. The tool addresses needs in the school environment, requests contact information for the school and shows attempts to obtain the individualized IEP or 504 Plan, SDoH, BH, durable medical equipment and home health supplies, other medical or care coordination services and provides a follow-up plan for future care and appointments.
- Limited cultural preferences were documented which included preferred language, ethnic group and religious or spiritual beliefs for members with BH needs on the BH assessment.
- Evidence of referrals for community resources and member interactions are clearly documented in the care coordination assessment tool, care coordination and clinical notes which are accessible to all team members. It is clear that all team members document and assess for SDoH.

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 7,383 assigned PCMH+ membership. FHCHC's reports the following care coordination contacts: April 2017: 88 contacts; May 2017: 194 contacts; June 2017: 185 contacts in June 2017; July 2017: 100 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.
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.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
PH-BH Integration	FHCHC is currently developing their Wellness Recovery Action Plan process and how they will identify members who will benefit from Wellness Recovery Action Plan planning. They are developing their own recovery action plan using nationally available evidenced based tools as a guide.	Finalize the Wellness Recovery Action Plan process and ensure that for members who would benefit, that a Wellness Recovery Action Plan or other recovery action plan is developed in collaboration with the member and family.
Member File Reviews	FHCHC is still implementing the process to verify the presence of a psychiatric advance directive.	Formalize procedures to ask members if they have a psychiatric advance directive and methods to document the presence of a psychiatric advance directive in the member file.
	FHCHC is still developing Wellness Recovery Action Plan processes and identifying those members who would benefit from a Wellness Recovery Action Plan.	Formalize procedures to identify members who would benefit from Wellness Recovery Action Plan and the process to develop Wellness Recovery Action Plans with those members.

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