HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

OPTIMUS HEALTH CARE

JANUARY 4, 2019

State of Connecticut

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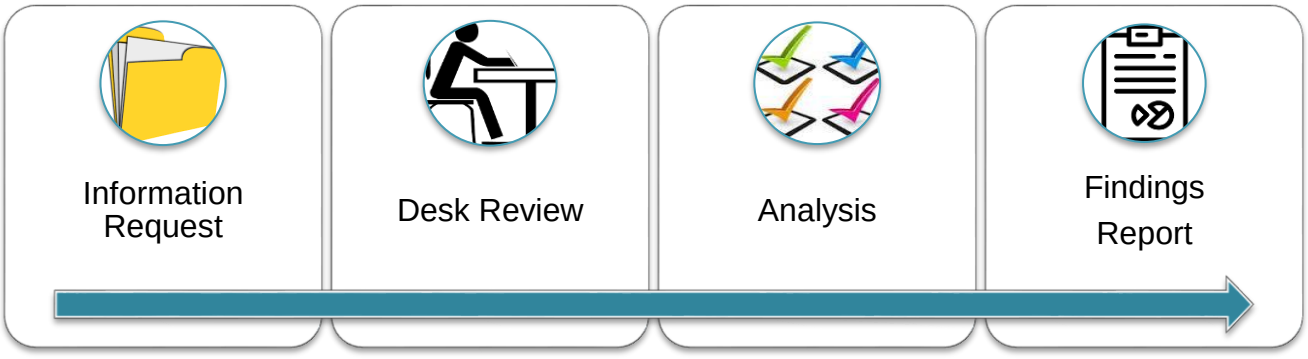
INTRODUCTION

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 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 Optimus Health Care 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

OPTIMUS HEALTH CARE PCMH+ PROGRAM OVERVIEW

Optimus Health Care (OHC) is a Federally Qualified Health Center providing community primary care, behavioral health (BH) and dental services. OHC operates 18 sites in Bridgeport, one site in Stratford, two sites in Milford, five sites in Stamford and 10 school-based health centers in both Bridgeport and Milford and serves a largely Hispanic population.

OHC continues to utilize a team-based approach to provide enhanced care coordination activities to 19,962 PCMH+ members (Wave 1 attribution totaled 20,562 members). The PCMH+ team consists of 9.5 Care Coordinators. Six of the Care Coordinators are Community Health Workers, two are Registered Nurse (RN) Care Managers and 1.5 are Behavioral Health Care Coordinators (who are all .50 FTEs). The Care Coordinators provide a variety of member supports including, but not limited to; health education, development and monitoring of member-specific goals, access to support services such as food, housing, and transportation, notifying members of any programs and community services they are eligible for and maintaining of member engagement by providing support via frequent follow-ups and coordination of services onsite and during home visits.

Since July 2017, OHC has reported a penetration rate of less than 1% month-over-month. In the first quarterly report of 2018, OHC reported 326 unique PCMH+ members received a care coordination contact. On average, OHC reports 109 unique PCMH+ members received a care coordination contact on a monthly basis.

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

For Wave 2, OHC has developed a training curriculum which encompasses training on culturally and linguistically appropriate services (CLAS), Americans with Disabilities Act, motivational interviewing techniques and social determinants of health (SDoH) screening. OHC has also developed clinical trainings to better understand their members' conditions which include screening for BH conditions, diabetes, cardio-vascular disease and asthma supports. OHC has also developed formal transformational workflows and processes to support the integration of SDoH and BH into their program.

OHC has changed the role of two of their RNs from floor RNs to RN Care Managers. This new role is intended to support OHC's medium and high-risk members. The implementation and adoption of these new roles are still a work in progress for OHC and some workflows and processes around member care management are in development as this model is to be replicated at all six of OHC's sites.

Additionally, OHC has developed new workflows to support the transition of care between departments (BH, dental, OB/GYN, pediatric and internal medicine). OHC has implemented new software providing interoperability between hospitals and OHC which allows their care team to instantly know about hospitalization and emergency room visits of their members. With this ability, OHC has implemented new formal processes to offer fast follow-up visits and medical advice to these members that were hospitalized or visited the emergency room. Additionally, OHC is working on establishing a dialogue with their pediatric member's schools to offer seamless BH and primary care to its members. This dialogue would also include the ability to obtain copies of individualized education plans (IEPs) and 504 Plans for their members.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

OHC is now able to utilize their electronic medical record as the only repository of all health related information, including the SDoH assessment and BH screenings. OHC also reports that they have had success integrating SDoH and BH into their primary care models. OHC has conducted trainings with its residents on this concept as well as ways to utilize their Community Health Workers, allowing future primary care providers to understand this new model of care.

Lastly, OHC reports that it has developed a member relation program to improve response to member grievances and address suggestions for improvement to the PCMH+ program.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

OHC reported experiencing several programmatic challenges; however, the vast majority of the challenges experienced are outside of the scope of this review and pertain to the larger Medicaid program. Challenges reported included; staffing for their Behavioral Health Care Coordinator and RN Care Manager positions due to limited qualified candidates, as well as high turnover in the positions and until recent upgrades, OHC's electronic medical record not having the capability for SDoH screenings or Wellness Recovery Action Plans. OHC also reported that they have streamlined their electronic medical templates to facilitate the care coding by their providers. After each required upgrade of their electronic medical record the "home-made electronic templates" became corrupted and needed to be rebuilt. They have not found a solution as of yet to prevent this corruption the next time an upgrade is needed.

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

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Program Operations	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the Performance Improvement Committee meetings such that OHC demonstrates compliance with the "substantial representation" requirement within PCMH+.	Since the last compliance review, OHC has made great progress in this area. OHC has held seven oversight meetings through June 2018 with average of five PCMH+ voting members in attendance.	Met
	Evaluate current PCMH+ care coordination member penetration rate, and develop a process to increase the number of PCMH+ members engaged in care coordination activities.	OHC penetration rates have remained low since the last compliance review (consistently less than 1%). On the April–June quarterly report, OHC continued to report a penetration rate of less than 1%. OHC reports a total of 666 (222 monthly) care coordination contacts made during the reporting timeframe. With 9.5 Care Coordinators, this equates to approximately 23 care coordination contacts per month per Care Coordinator.	Partially Met
Physical Health-Behavioral Health (PH-BH) Integration	Ensure BH screenings and follow up for positive screens are clearly documented. Identify and implement BH screens appropriate for adolescent and pediatric populations.	OHC did develop a new policy and procedure on the BH referral process; however, the member file review shows that there continues to be inconsistent evidence of universal BH screening. However, in those cases when members were screened, OHC utilizes a variety of screening tools such as the Patient Health Questionnaire (PHQ) 2/9, the Generalized Anxiety Disorder (GAD-7), the Primary Care-Post-Traumatic Stress Disorder (PC-PTSD) and CAGE-AID (a substance use screen). There did not appear to be a policy to screen adolescents for BH needs.	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 to address the recommendation are required.

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
Children and Youth with Special Healthcare Needs (CYSHCN)	Develop a process to identify CYSHCN and to collect school information, including IEPs and 504 Plans where applicable for incorporation into the member's plan of care.	OHC has shown evidence of the ability to identify CYSHCN through their monthly and quarterly reporting but continues to be unable to collect member's IEPs and 504 Plans. OHC reports that their pediatricians make written requests to the school for IEP documentation, the school social workers have ultimately shared that the IEPs are to be provided by parents if they are willing to. OHC has evidence in the electronic medical record on the pediatrician requests. Member file reviews also indicate that when a Community Health Worker is engaged with a CYSHCN member, they inquire about educational levels and the presence of special education needs.	Met
Member File Reviews	Consider development of a plan of care that can be used by both BH and PH PCMH+ staff to promote communication of member's needs across the treatment team.	OHC reports they have developed integrated care plan templates for both PH and BH needs. However, due to electronic medical record recent upgrades, there has been barriers in fully rolling out their plan. The review of member files demonstrated there continues to be limited evidence of consistent practices for developing member plans of care. BH team members do utilize a multidisciplinary team plan which is comprehensive in nature, but it is not used consistently for members with BH conditions.	Not Met
	Formalize procedures to promote universal BH screening for PCMH+ members.	As stated previously, OHC did develop a new policy and procedure on the BH referral process. However, there continues to be inconsistent evidence of universal BH screening. However, in those cases when members were screened, OHC utilized screening tools such as the PHQ-2/9, GAD-7, PC-PTSD and CAGE-AID. There did not appear to be a policy to screen adolescents for BH needs.	Partially Met

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
	Formalize procedures to collect members' cultural needs and preferences and incorporate them into the care plan.	OHC continues to collect information about member language, religious preferences, racial and ethnic identities. OHC has expanded the collection of cultural preferences to include if the member's religion includes any medical restrictions. Community Health Work progress notes also indicate if there are any cultural barriers that impact care. However, for members with BH needs, there was no evidence of incorporating cultural needs into BH clinical notes, unless a Community Health Worker was assigned to the member.	Partially Met
	Formalize procedures to provide education to members about Wellness Recovery Action Plan and the process to develop them.	The review of member files confirmed that OHC has made progress in this area. OHC has developed a Wellness Recovery Action Plan group which educates members about Wellness Recovery Actions Plans and assists them to develop them. OHC has also consistently reported monthly and quarterly on the number of member Wellness Recovery Action Plans obtained and developed and placed into the member's record.	Met
	Formalize procedures to assess members about the presence of a psychiatric advance directive and methods to store them in the member file.	OHC has not made progress in this area and reports that the members who are eligible for this tool are directed to use the Mayor's office as it is equipped with the staff to provide these psychiatric advance directives. In the event, these are completed, the members are instructed to share with their BH providers. The review of member files shows no evidence of the OHC staff asking members if they have a psychiatric advance directive.	Not Met

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

AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	OHC penetration rates have remained consistently below 1%.	Evaluate PCMH+ enhanced care coordination member penetration rates and formalize procedures to increase the number of PCMH+ members engaged in care coordination activities.
PH-BH Integration	OHC does not consistently screen members for BH conditions.	Formalize processes to conduct universal BH screening for all members, including adolescent members.
	OHC does not utilize consistent practices for developing member plans of care.	Formalize processes for developing a universal member plan of care that can be used by both PH and BH staff to promote communication of member's needs across the treatment team.
	OHC does not document if a member has a psychiatric advance directive and does not report counts of members with a psychiatric advance directive on the monthly/quarterly reports.	Formalize procedures to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record. Formalize procedures to report counts of members with psychiatric advance directives on quarterly reports.
	OHC reports the counts of Transition Age Youth with transition care plans on their monthly/quarterly reporting but does not document transition care planning for Transition Age Youth in member files.	Formalize procedures to document transition care planning for Transition Age Youth in the member's electronic medical record.
Community Linkages	Members who are not engaged with a Community Health Worker, including BH members, do not appear to be screened for SDoH.	Formalize procedures to expand screening for SDoH by Community Health Workers to all PCMH+ members, including members with BH needs.

RESULTS

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

Regarding psychiatric advance directives, it is important to note that the PCMH+ requirement is not to develop a psychiatric advance directive with a member. Rather, the requirement is to inquire if the member has a psychiatric advance directive, and if so, obtain a copy for the member file. Documentation of a member's declination of a psychiatric advance directive is sufficient to meet the requirement.

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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 OHC develop a plan to recruit and retain sufficient PCMH+ members to participate in the Performance Improvement Committee meetings such that OHC demonstrates compliance with the “substantial representation” requirement within PCMH+. Since the last compliance review, OHC has made significant progress in this area. OHC has held seven oversight meetings through June 2018 with average of five PCMH+ voting members in attendance.
- Due to low penetration rates in the first six months of PCMH+, it was also recommended that OHC evaluate current PCMH+ care coordination member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities. OHC penetration rates have remained low (consistently less than 1%). On the April–June quarterly report, OHC continued to report a penetration rate of less than 1%. OHC reports a total of 666 (222 monthly) care coordination contacts made during the reporting timeframe. With 9.5 Care Coordinators, this equates to approximately 23 care coordination contacts per month per Care Coordinator.
- OHC 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 is completed through monthly and quarterly reporting. OHC has consistently met this requirement. OHC 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, OHC did not have any recommendations for improvement in this area. No underservice was noted during the review. OHC has an underservice policy that tracks provider panels and health disparities across the organization.

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 OHC ensure BH screenings, and follow-up for positive screens, are clearly documented in the member's file and identify and implement BH screens appropriate for adolescent and pediatric populations. OHC has stated that they are reviewing and testing different workflows to facilitate BH referrals and working on bottlenecks. OHC did develop a new policy and procedure on the BH referral process; however, the member file review showed that there continues to be inconsistent evidence of universal BH screening. However, in those cases when members were screened, OHC utilizes screening

tools such as the PHQ-2/9, GAD-7, PC-PTSD and CAGE-AID. There did not appear to be a policy to screen adolescents for BH needs.

- It was also recommended that OHC consider development of a plan of care that can be used by both PH and BH PCMH+ staff to promote communication of member's needs across the treatment team. OHC noted that they have integrated care plan possibilities for both. However, due to electronic medical record recent upgrades, there has been barriers in fully rolling out their plan. The review of member files demonstrated that there continues to be limited evidence of consistent practices for developing member plans of care. BH team members do utilize a multidisciplinary team plan which is comprehensive in nature, but it is not used consistently for members with BH conditions.
- Another recommendation was for OHC to formalize procedures to assess members about the presence of a psychiatric advance directive and methods to store them in the member file. OHC has not made progress in this area and reports that the members who are eligible for this tool are directed to use the Mayor's office as it is equipped with the staff to provide these psychiatric advance directives. In the event, these are completed, the members are instructed to share with their BH providers. The review of member files shows no evidence of the OHC staff asking members if they have a psychiatric advance directive.
- One other recommendation was for OHC to formalize procedures to provide education to members about Wellness Recovery Action Plans and the process to develop them. The review of member files confirmed that OHC has made progress in this area. OHC has developed a Wellness Recovery Action Plan group which educates members about Wellness Recovery Actions Plans and assists them to develop them.
- OHC had no other recommendations for improvement in this area; however, counts of members with BH needs, members screened for BH conditions, members with wellness recovery action plans and Transition Age Youth with transition care plans and the number of interdisciplinary team meetings held is monitored through monthly and quarterly reporting. OHC has consistently met this requirement; however, even though OHC reports the counts of Transition Age Youth with transition care plans on their monthly/quarterly reporting, there was no evidence of transition care planning for Transition Age Youth per the member file review. OHC has also completed and submitted the PCMH+ report on a timely basis each month and now on a quarterly basis.

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 OHC develop a process to identify CYSHCN and to collect school information, including IEPs and 504 Plans where applicable for incorporation into the member's plan of care. OHC has shown significant progress with the identification and reporting of their CYSHCN population but has not reported being able to collect member's IEPs and 504 Plans. OHC reports that their pediatricians make written requests to the school for IEP documentation, the school social workers have ultimately shared that the IEPs are to be provided by parents if they are willing to provide them. The member file reviews provided evidence that of the pediatrician's efforts to obtain IEPs and 504 Plans.
- Additionally, a review of member files indicates that when a Community Health Worker was engaged with a CYSHCN member, Community Health Worker inquired about educational levels and the presence of special education needs.

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, OHC 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, OHC 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.
- OHC reported that they had developed a training curriculum both encompassing training on CLAS, ADA, motivational interviewing techniques, social determinant of health screening, as well as clinical trainings to understand their member's conditions (the training included screening for BH conditions, diabetes, cardio-vascular disease and asthma supports). OHC developed formal transformational workflows and processes to support the integration of social determinant of health and BH to primary care and support the sustainability of this program.

- Staff disability competency trainings are monitored in monthly and quarterly reporting. Based on this reporting, OHC has continued to hold disability competency trainings at least annually with all staff as well as a separate onboarding training for new staff.

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 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, it was recommended that OHC formalize procedures to collect members' cultural needs and preferences and incorporate them into the care plan. OHC reported that the RN Care Managers collect information about member language, religious preferences, racial and ethnic identities and incorporate this information into the member's care plan.
- A review of member files indicates that OHC has expanded the collection of cultural preferences to include if the member's religion includes any medical restrictions. Community Health Work progress notes also indicate if there are any cultural barriers that impact care. However, for members with BH needs, there was no evidence of incorporating cultural needs into BH clinical notes, unless a Community Health Worker was assigned to the member.
- Staff cultural competency trainings are monitored in monthly and quarterly reporting. Based on this reporting, OHC has continued to hold cultural competency trainings at least annually with all staff as well as a separate onboarding training for new staff. As previously reported, OHC has developed a training curriculum both encompassing training on CLAS, ADA, motivational interviewing techniques, social determinant of health screening, as well as clinical trainings to understand their member's conditions.

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, OHC 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, OHC 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, OHC's resource list included over 55 community resources that included organizations providing services such as housing, food assistance, employment, transportation, mental health and addiction, literacy and senior services.
- A review of the member file reviews indicates that OHC does not utilize a formal assessment for SDoH; however, when a Community Health Worker was engaged with a member, the clinical notes demonstrate a review of SDoH. The assessment varied from member to member, but elements included financial status, employment status, access to food, support systems, living arrangements and transportation needs.
- Additionally, it was noted that OHC's Community Health Workers clearly document member interactions and referrals to community resources in the member file. There continues to be strong evidence that the Community Health Workers are successful in helping members to coordinate a variety of needs (e.g., access to transportation, food resources and completion of forms). Community Health Worker notes are accessible to all team members in OHC's electronic medical record, Epic®.

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 an RN) who reviewed a total of 20 member files.

B. Member File Review Findings

- OHC has shown limited evidence of consistent practices for developing member plans of care. BH team members do utilize a multidisciplinary team plan which is comprehensive in nature, but it is not used consistently for members with BH conditions.
- OHC's member files continue to show inconsistent evidence of universal BH screening in member files. However, in those cases when members were screened, OHC utilizes screening tools such as the PHQ-2/9, GAD-7, PC-PTSD and CAGE-AID. There does not appear to be a policy to screen adolescents for BH needs.
- OHC has developed a Wellness Recovery Action Plan group which educates members about Wellness Recovery Action Plans and assists them in the development of these plans. However, it is unclear the criteria used to identify which members would benefit from the group.
- There was no evidence of asking members if they have a psychiatric advance directive.
- For Transition Age Youth, there is no evidence of transition planning.
- OHC continues to collect information about member language, religious preferences, racial and ethnic identities. OHC has expanded the collection of cultural preferences to include if the

member's religion includes any medical restrictions. Community Health Work progress notes also indicate if there are any cultural barriers that impact care. However, for members with BH needs, there was no evidence of incorporating cultural needs into BH clinical notes, unless a Community Health Worker was assigned to the member.

- OHC does not utilize a formal assessment for SDoH; however, when a Community Health Worker was engaged with a member, the clinical notes demonstrate a review of SDoH. The assessment varied from member to member, but elements included financial status, employment status, access to food, support systems, living arrangements and transportation needs. For CYSHCN, the assessment inquires about educational level and presence of special education needs. It does not appear that members with BH needs are screened for SDoH.
- OHC Community Health Workers clearly document member interactions and referrals to community resources in the member file. There continues to be strong evidence that the Community Health Workers are successful in helping members to coordinate a variety of needs (e.g., access to transportation, food resources and completion of forms). Community Health Worker notes are accessible to all team members in OHC's electronic medical record, Epic®.

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 Performance Improvement Committee meetings. OHC's May and June PCMH+ Monthly reports indicated there were no PCMH+ members in attendance.	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the Performance Improvement Committee meetings such that OHC demonstrates compliance with the "substantial representation" requirement within PCMH+.
	Enhanced care coordination member penetration rates are low for the 16,294 assigned PCMH+ membership. The PE reports the following monthly care coordination contacts: April 2017: 27 contacts; May 2017: 72 contacts; June 2017: 137 contacts; July 2017: 272 contacts.	Evaluate current PCMH+ care coordination member penetration rate, and develop a process to increase the number of PCMH+ members engaged in care coordination activities.
PH-BH Integration	BH screenings are not consistently documented. OHC is in process of identifying appropriate screening tools for use with adolescent and pediatric populations.	Ensure BH screenings and follow up for positive screens are clearly documented. Identify and implement BH screens appropriate for adolescent and pediatric populations.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
CYSHCN	There is currently not a formal process to identify CYSHCN or to obtain IEPs and 504 Plans.	Develop a process to identify CYSHCN and to collect school information, including IEPs and 504 Plans where applicable for incorporation into the member's plan of care.
Member File Reviews	There is limited evidence of consistent practices for developing member plans of care.	Consider development of a plan of care that can be used by both BH and PH PCMH+ staff to promote communication of member's needs across the treatment team.
	There is limited evidence of universal BH screening.	Formalize procedures to promote universal BH screening for PCMH+ members.
	There was limited evidence demonstrating how cultural needs are incorporated into the care plan.	Formalize procedures to collect members' cultural needs and preferences and incorporate them into the care plan.
	The PE is still developing methods to educate members about Wellness Recovery Action Plan and support them through the Wellness Recovery Action Plan development process.	Formalize procedures to provide education to members about Wellness Recovery Action Plan and the process to develop them.
	There is limited evidence of consistently asking members if they have a psychiatric advance directive.	Formalize procedures to assess members about the presence of a psychiatric advance directive and methods to store them in the member file.

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