HEALTH WEALTH CAREER

2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF CORNELL SCOTT-HILL HEALTH CORP.

AUGUST 29, 2017

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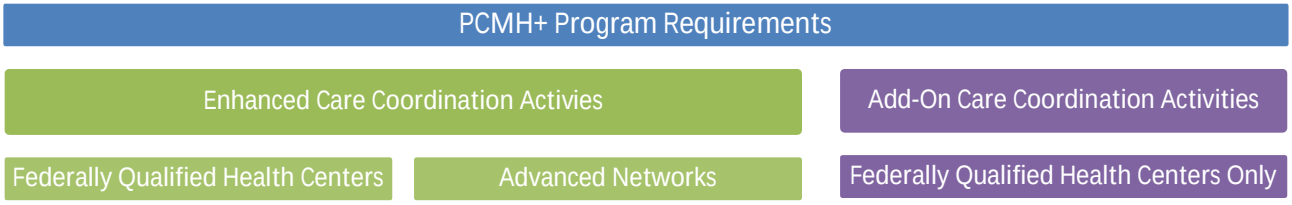
INTRODUCTION

The Person-Centered Medical Home Plus (PCMH+) program is part of the Connecticut Department of Social Services' (DSS) investment in value-based purchasing and care coordination to reduce Medicaid expenditures while improving service quality and member health outcomes. PCMH+ builds on the DSS PCMH program started by DSS January 1, 2012 currently serves 61% of HUSKY Medicaid members and has successfully supported the practice transformation of 112 practices (as of September 2017) to achieve PCMH recognition. PCMH+ is a Shared Savings model where a participating entity (PE) that meets specific quality improvement targets and saves money for the program, may share in a portion of HUSKY program savings. The PE's quality measure scoring and PCMH+ program savings calculations, for Wave 1 (PCMH+ Program Year 1) will be conducted Fall 2018 and are not evaluated as part of this PCMH+ Compliance Review. This review is focused on evaluating PCMH+ PE compliance with PCMH+ program requirements, identifying best practices and opportunities for improvement.

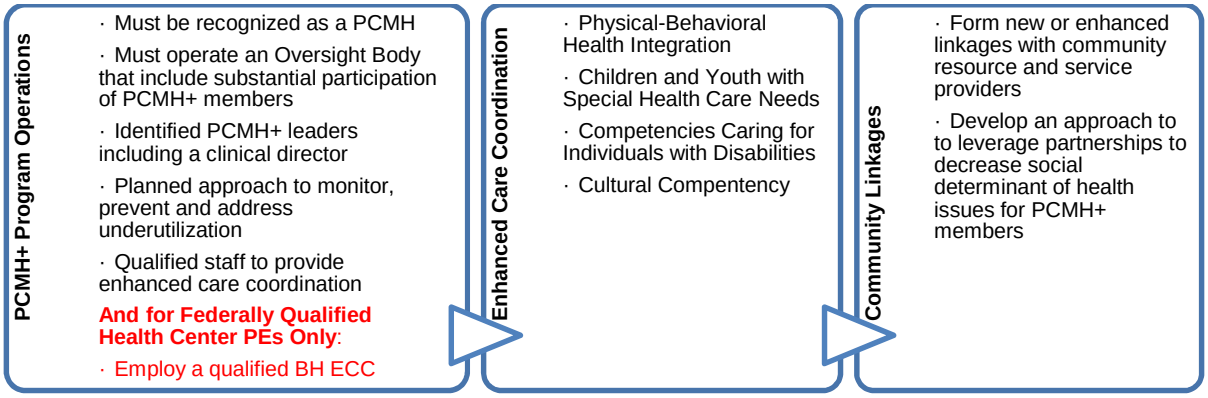
DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite for eligibility for the PCMH+ program.

PCMH+ PROGRAM REQUIREMENTS

PCMH+ expands care coordination provided to members through required Enhanced Care Coordination interventions and actively promotes physical and behavioral health integrated service delivery. The PCMH+ program requirements include enhanced care coordination activities and operational standards that all PEs must meet.

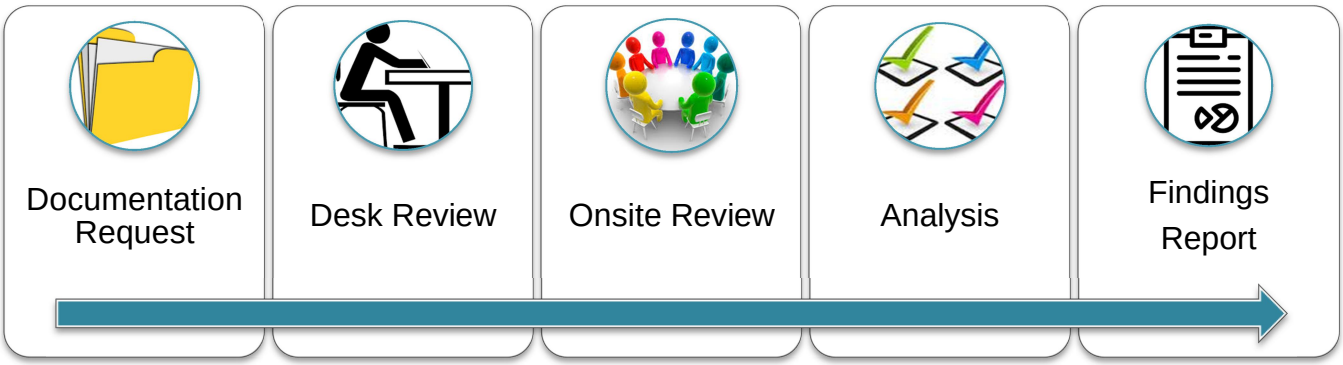


For PEs, like Cornell Scott-Hill Health Corporation (CS-HHC), that are a federally qualified health center, there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice, including a qualified BH enhanced care coordinator (ECC) on staff who is an active participant in the CS-HHC's interdisciplinary team(s) and development of Wellness Recovery Action Plans for members with BH conditions. The following table provides a summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are in Section 3.



REVIEW METHODOLOGY

The PCMH+ Wave 1 program review focused on evaluating operations and service delivery, including compliance with program standards, quality and effectiveness in achieving the goals of the DSS PCMH+ program. The review evaluated the implementation and operations of the PE's PCMH+ program since the go-live date of January 1, 2017 through August 2017 and was organized into five phases presented in the following diagram:



DOCUMENT REQUEST — JUNE 2017

Mercer developed a comprehensive PCMH+ Document Request that was shared with the PE in an effort to gather information regarding the PE's PCMH+ program. The request solicited a variety of documents, such as organizational charts, PCMH+ staffing, member participation in oversight, policies and procedures regarding care coordination, community linkages and assistance of members with special healthcare needs and disabilities, related to the PCMH+ program requirements. In addition, the Documentation Request solicited brief narrative responses to questions related to the implementation of the PCMH+ program in an effort to understand the PE's operations and approach to implementing the PCMH+ program within their practice(s).

DESK REVIEW — JULY 2017

Mercer received information electronically and reviewed all documents submitted to evaluate the PE's compliance with PCMH+ program requirements as detailed within the PCMH+ Request for Information. Areas where Mercer could not determine that the process or procedure was fully

compliant with PCMH+ program standards were noted for follow-up discussion during the onsite interviews.

ONSITE REVIEW — AUGUST 2017

The onsite review for CS-HHC took place on August 29, 2017, at the offices located in New Haven, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff, and appropriate CS-HHC leadership. After the introductory session, the track teams split out into concurrent sessions and concentrated on the following areas focused specifically on PCMH+ program operations and PCMH+ assigned members; Program Operations, Enhanced Care Coordination, Member File Reviews, Member Interviews and Community Linkages. Onsite interviews including the following CS-HHC staff:

- Lou Brady — COO
- Kelvin Kreho — CFO
- Mark Silvestri — Medical Director of Quality Operations
- Vanessa Andrews — Compliance Officer
- Robert Bruce — Chief of Medicine
- Lavita Robinson, MD, MPH — Internal Medicine Physician
- Rose Swift — Director, Grant Programs and Research
- Tasha Hamblin — Business Intelligence Analyst
- Jeannette James — Executive Assistant
- Pamela Fox — Director of Care Coordination
- Cynthia Scott — Assistant Manager of Care Coordination
- Sherlyne Dieudonne — BH Complex Care Manager
- LaRonda Winfrey — ECC
- Natacha Ramos — ECC
- Keiana Fox — ECC
- Omar Lafayette — ECC
- Katherine Gonzales — ECC

ANALYSIS AND FINDINGS REPORT — SEPTEMBER 2017

Information from all phases of the assessment process was gathered and a comprehensive analysis was completed. Results of this analysis make up this report.

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SUMMARY OF FINDINGS

CS-HHC PCMH+ PROGRAM OVERVIEW

CS-HHC is a federally qualified health center established in 1968, in collaboration with the community and the Yale School of Medicine, providing its members an array of primary care and specialist care, including audiology, 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, has recently opened partner care sites at the Connecticut Mental Health Center and Gateway Community College and operates a pilot Medication Therapy Management program. This pilot Medication Therapy Management program allows CS-HHC's pharmacists to function as extended members of their integrated care team. Pharmacists counsel members, including PCMH+ members, who take multiple medications and/or have made multiple visits to hospital emergency departments, to help them improve their health via better medication management. During Medication Therapy Management appointments, the pharmacists review and organize all medications with members to identify potential drug interactions and duplications, while educating members on how to take their medications.

Under PCMH+, CS-HHC provides enhanced care coordination activities to 12,979 PCMH+ members utilizing six ECCs and two supervisory staff; one Director of Care Coordination, one Assistant Manager of Care Coordination, one BH ECC and five ECCs. Of these staff members, two ECCs are bilingual. The BH ECC works to support PCMH+ members at all of CS-HHC's locations, while the ECCs have designated days assigned to particular locations of care. CS-HHC selected a care team (pod) approach in administering care coordination in an effort to foster an integrated, multidisciplinary approach and holistically address their members physical and mental health needs. As of the July PCMH+ Monthly reporting, CS-HHC reports the following monthly care coordination contacts: April 2017: 110 contacts; May 2017: 273 contacts; June 2017: 303 contacts and July 2017: 337 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	CS-HHC leverages the Community Heath Network of Connecticut (CHNCT) provided Care Analyzer, acuity scores, member information within their Epic® electronic health record, and gaps in care reporting to identify members with care needs and refers these members to ECCs for assessment and care coordination support.

REVIEW AREA	STRENGTH
Physical Health-Behavioral Health Integration	CS-HHC has delivered integrated physical health-behavioral health services for many years and had previously established procedures to ensure all members have access to BH services if needed. The provision of integrated physical health-behavioral health care is a core tenant of the PCMH+ program and positions CS-HHC to deliver enhanced care coordination. One of the primary tasks of the BH ECC is to encourage members to utilize CS-HHC as their primary care setting in lieu of emergency departments.
	CS-HHC screens all members universally for both depression and substance use disorders on an annual basis.
	CS-HHC utilizes a warm hand off process to ensure linkages to BH services following a positive behavioral screen.
	CS-HHC's BH clinicians consistently ask members, including transition age youth, whether they have a psychiatric advance directive and will assist members to complete one if desired.
	CS-HHC has developed both adult and pediatric Wellness Recovery Action Plans which are fully integrated into the electronic health record. All team members can access the document and associated notes through the electronic health record.
Children and Youth with Special Healthcare Needs	CS-HHC provides a diverse set of pediatric programs to the children they serve, including an early childhood program for children age birth to three, a nurturing family program for families who are post-natal, a healthy start program for pre-natal families and a child and family guidance center. They operate five school-based health centers and are in the process of developing a shared platform to improve communication and coordination of care of mutually-served members.
Competencies in Care for Individuals with Disabilities	CS-HHC collects information about member's disabilities and related needs through the health risk assessment (including an assessment of activities of daily living). CS-HHC identifies members with disabilities in the electronic health record and has identified approximately 935 PCMH+ members as individuals with disabilities.
Cultural Competency	CS-HHC is committed to hiring a diverse workforce that represents the diversity of the members served; many of staff are bilingual with various cultural influences.
	CS-HHC offers annual cultural competency training to newly hired staff during the onboarding process and on an annual basis thereafter. The training includes the unique needs of members with disabilities.
	CS-HHC consistently documents member cultural needs and preferences in the member's record and ECCs engage directly with members to understand their cultural needs and preferences.
Community Linkages	CS-HHC utilizes the health risk assessment to identify social determinants of health, promote member discussions regarding health and wellbeing challenges and goals for better health outcomes which are documented in the electronic health record.
	The care coordinators actively link members to community resources based on an assessment of social determinants of health.
	ECCs have built a comprehensive resource list that is housed in a shared drive. All care coordinators have access to this drive and update the list as needed to ensure the information is accurate and up-to-date. ECCs also access CT 2-1-1 as needed to meet the comprehensive needs of members.

REVIEW AREA	STRENGTH
Member File Reviews	The electronic health record clearly identifies members as PCMH+.
	CS-HHC uses a comprehensive assessment tool that includes communication, health literacy, digital literacy and physical health-behavioral health. The tool is available in both English and Spanish.
	CS-HHC uses an internal resource list to refer members to community resources.
	CS-HHC coordinates care for provider visits, prescriptions, dental, transportation, housing, etc. CS-HHC also conducts home visits and assessments for members transitioning between care settings or with high needs.
	CS-HHC has uses an electronic health record that integrates physical and BH information.
	CS-HHC collects a comprehensive set of cultural preferences and needs which are clearly documented on in the member record.

OPPORTUNITIES

Note the Recommendations for Improvement Plan is found in Appendix A of this report.

REVIEW AREA	OPPORTUNITY
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.
	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.
Member File Reviews	CS-HHC does not have a distinct social determinants of health screening tool or intervention summary.

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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.
- Having a quality program, including annual goals and annual quality work plan that includes specific PCMH+ program goals and activities.
- Evaluating and utilizing the results of provider profile reports to improve the quality of care.
- Completing and submitting the PCMH+ monthly report based on specifications provided by DSS.

B. PCMH+ Program Operations Findings

- CS-HHC leverages the CHNCT provided Care Analyzer, acuity scores, member information within the Epic® electronic health record, and gaps in care reporting for member stratification and are developing internal clinical quality measure reporting, including many measures that are part of the PCMH+ program. These reports are shared with clinical teams supporting the ECCs once the reporting is validated. The Assistant Manager of Care Coordination uses this information to identify high-risk members and refers to the ECC, who meets with the member to conduct an assessment and work with the member, provider, and internal and external services to resolve any resource needs or gaps in care.
- CS-HHC conducts member experience surveys through a contracted vendor who has national federally qualified health center benchmarking information.
- The Quality Assurance/Quality Improvement Committee serves as CS-HHC's PCMH+ oversight body. The committee meets monthly and monitors and recommends system improvements to enhance quality of care, provider productivity, member satisfaction, and all aspects of health services delivered throughout the organization. The committee reviews the PCMH+ program at least once per quarter. CS-HHC has held two Quality Assurance/Quality Improvement Committee meetings and had one PCMH+ member attend in February 2017 and one PCMH+ member attend in May 2017.
- CS-HHC's quality program description includes the model used, the program structure, role and members of the Quality Assurance/Quality Improvement Committee, goals and

evaluation criteria. The quality program does not include the PCMH+ program or how the PCMH+ program is evaluated or contributes to CS-HHC's quality goals.

- CS-HHC created an internal PCMH+ project team to provide oversight and management for all deliverables to ensure proper execution of the PCMH+ contract requirements. This core team included representation from Operations, Care Coordination, IT and Medical. CS-HHC utilizes their Quality Assurance/Quality Improvement Committee to provide program governance.
- 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.

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 complex members with higher cost needs 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

- There was no evidence of underservice noted during the review.
- CS-HHC has a formal "Code of Conduct" that outlines behavior expectations of all staff. It includes information regarding conflicts of interest, respect and non-discrimination of members.
- CS-HHC indicates that no provider independently has the ability to manipulate their member panel and in order for members to change providers, there is a formalized "provider change request" process that must be followed, which goes through medical administration for approval.
- CS-HHC monitors member grievances and preventative care measures formally through their Quality Assurance/Quality Improvement Committee and solicits member feedback through board participation, and with PCMH+, member advisory board participation. As noted above, Quality Assurance/Quality Improvement Committee member participation is currently limited to one member. However, member feedback is also solicited via a telephonic member survey that targets around 4,000 members and is conducted annually in the first quarter.

ENHANCED CARE COORDINATION

A. Physical Health-Behavioral Health (PH-BH) Integration Requirements

Increased requirements for PH/BH integration align with the goals of the PCMH+ program and follow national trends in healthcare. PCMH+ PH-BH requirements include:

- Using standardized tools to expand behavioral health 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; and
- Obtaining and maintaining a copy of a member's Wellness Recovery Action Plan in the member's file.
- Expanding development and implementation of the care plan for transition age youth with BH challenges.
- For federally qualified health centers only: Develop Wellness Recovery Action Plans in collaboration with the member and family.

B. PH-BH Integrated Findings

- CS-HHC screens all members universally for both depression and substance use disorders on an annual basis using the PHQ-2/9 with additional substance abuse questions. The initial screening is completed by the medical assistants when vitals are collected.
- CS-HHC is screening for BH conditions beyond depression, and uses tools such as the Ohio MH Consumer Outcomes system which screens youth for BH challenges and the BASIS-24 tool (Behavior and Symptom Identification Scale) which screens adults for BH conditions.
- CS-HHC utilizes a warm hand off process to ensure linkages are made to BH services following a positive behavioral screen. The referral is completed by either the BH ECC or by the primary care provider. Members with positive screens are flagged in the electronic health record which notifies the BH ECC to engage with the member. If possible, the BH ECC will attempt to meet directly with members immediately after primary care provider appointments to assess BH needs.
- CS-HHC has employed a BH ECC, who transitioned to PCMH+ from another role. The BH ECC provides care coordination at all CS-HHC sites and travels extensively to provide face-to-face services as needed. One of her primary tasks is to encourage members to utilize CS-HHC as their primary care setting in lieu of emergency departments. She also assists with re-engaging members discharged from ambulatory detoxification programs who have not yet reconnected with their primary care provider.
- CS-HHC's BH clinicians consistently ask members, including transition age youth, whether they have a psychiatric advance directive and if not, will assist members to complete one if desired. The BH ECC also engages with members to provide information about psychiatric advance directives and provides the support needed to complete a psychiatric advance directive.
- CS-HHC has delivered integrated physical health-behavioral health services for many years and had previously established procedures to ensure all members have access to BH

services if needed. The provision of integrated physical health-behavioral health care is a core tenant of the PCMH+ program and positions CS-HHC to deliver enhanced care coordination. One of the primary tasks of the BH ECC is to encourage members to utilize CS-HHC as their primary care setting in lieu of emergency departments.

- CS-HHC has developed both adult and pediatric Wellness Recovery Action Plans which are fully integrated into the electronic health record. All team members can access the document and associated notes through the electronic health record. Referrals to develop Wellness Recovery Action Plans with members are sent to the ECCs, via the electronic health record. ECCs work directly with members, sometimes over multiple sessions, to develop the Wellness Recovery Action Plan. Members receive a hard copy of their Wellness Recovery Action Plan.
- CS-HHC conducts weekly interdisciplinary team meetings that include the RN, the ECC assigned to the specific site, the BH-ECC, the lead BH staff person and data specialist when needed. The team reviews high-complexity and high-cost members. The team develops an action plan for each member and reviews progress to the plan at each subsequent interdisciplinary team meeting.

A. Children and Youth with Special Health Care Needs Requirements

Children and Youth with Special Health Care Needs and their families often need services from multiple systems – health care, public health, education, mental health, and social services. PCMH+ Children and Youth with Special Health Care Needs requirements include:

- Holding advance care planning discussions for Children and Youth with Special Health Care Needs.
- Developing advance directives for Children and Youth with Special Health Care Needs.
- 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. Children and Youth with Special Health Care Needs Findings

- CS-HHC has developed their own definition of Children and Youth with Special Health Care Needs and currently identifies approximately 940 PCMH+ members that meet the criteria.
- CS-HHC provides a diverse set of pediatric programs to the children they serve, including an early childhood program for children age birth to three, a nurturing family program for families who are post-natal, a healthy start program for pre-natal families. They also have a child and family guidance center available. As noted, CS-HHC operates five school-based health centers and is in the process of developing a shared platform to improve communication and coordination of care of mutually-served members.

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 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 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

- CS-HHC collects information about member disabilities and related needs through the health risk assessment (including an assessment of activities of daily living). Member needs are documented on the member face sheet which is easily accessible to all staff who work with the member.
- CS-HHC identifies members with disabilities in the electronic health record and uses diagnoses as the primary method to flag a member. Diagnostic categories include members with visual or hearing impairments, cerebral palsy or other paralytic syndromes, intellectual disabilities, and pervasive or developmental disorders. CS-HHC has identified approximately 935 PCMH+ members as individuals with disabilities.
- CS-HHC offers adjusted appointment times to members with disabilities. The member's record is flagged to indicate the need for an adjusted appointment time and CS-HHC's scheduling system automatically generates the lengthier appointment. Appointment times are approximately 40 minutes long for members with this identified need.
- CS-HHC offers adaptive equipment for members who need assistance with transferring via a hi/low bed. Members who require this type of accommodation are flagged in the electronic health record and are scheduled to be seen in the examine room which contains the adaptive equipment.
- CS-HHC is beginning to offer trainings to increase staff competencies in caring for members with disabilities. CS-HHC provided training on service animals for staff to ensure members with service animals receive the accommodations needed while onsite.

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 determinant 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

- CS-HHC offers annual cultural competency training to newly hired staff during the onboarding process and on an annual basis thereafter. The training includes the unique needs of members with disabilities.
- CS-HHC is committed to hiring a diverse workforce that represents the diversity of the members served. Many of their staff are multicultural and bilingual (primarily Spanish-speaking). The BH ECC speaks English, Creole and French.
- ECCs engage directly with members to understand their cultural needs and preferences. Cultural needs are sometimes collected slowly as the care coordinator develops rapport with the member. ECCs shared that some members require multiple attempts at engagement to gain an understanding of their cultural needs.
- CS-HHC consistently documents member cultural needs and preferences in the member's record. If a member has a particular cultural need that may impact their health care and/or health outcomes, this need is documented under a "sticky note" in the electronic health record to ensure all team members are aware of this need.
- CS-HHC has recently added a "preferred location" identifier in the electronic health record which flags members who identify preferences for receiving their care at certain CS-HHC sites due to cultural needs. This has helped members who fear stigma about receiving care at certain sites (due to cultural factors).
- CS-HHC recently updated their Limited English-Speaking requirements to ensure standardized requirements for translation.

COMMUNITY LINKAGES

A. Community Linkages Requirements

In an effort to meaningfully impact PCMH+ members' social determinants of health issues, 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, nutrition, 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

- CS-HHC utilizes their health risk assessment to promote member discussions regarding challenges and goals. This discussion often leads to identification of social determinants of health which are documented under the member's social history. The health risk assessment is a part of the member record and all team members have access to the information collected.
- ECCs actively link members to community resources based on an assessment of social determinants of health. When a referral is completed, the care coordinator enters a referral into the electronic health record which includes a flag for estimated time for completion. The

electronic health record reminds the ECC of open referrals and helps to ensure the referral is completed in a timely manner and the member's needs are met.
- ECCs have built a comprehensive resource list that is housed in a shared drive. All ECCs have access to this drive and update the list as needed to ensure the information is accurate and up-to-date. ECCs also access CT 2-1-1 as needed to meet the comprehensive needs of members.

MEMBER FILE REVIEWS

A. Member File Review Process

PEs were instructed to provide 30 member files for the onsite review, from which the team would select 20 for review. A variety of files were solicited including those of:

- Five PCMH+ members who received at least two care coordination contacts since January 1, 2017.
- Five PCMH+ members who have a BH condition.
- Three PCMH+ members who are transition age youth or Children and Youth with Special Health Care Needs.
- Two PCMH+ members who have moved to another provider. If there were zero PCMH+ members who have moved to another provider, the PE was asked to provide two additional members who are either transition age youth or Children and Youth with Special Health Care Needs.
- Three PCMH+ members who are disabled.
- Two members who have transitioned from CHNCT Intensive Care Management Program.
- Five PCMH+ members who have not received a care coordination contact since January 1, 2017.
- Two members who have refused care coordination supports. If there were zero members who have refused care coordination, the PE was asked to provide two additional files for members who have been linked to community resources to address social determinants of health.
- Three members who were linked to community resources to address social determinants of health.

To accommodate multiple reviewers, the Mercer and DSS teams requested that member clinical records be printed for onsite review. If printed clinical records were not an option due to challenges with the electronic health record, the PE was asked to provide files electronically during the onsite session.

We asked that files include:

- Member demographics.
- All member assessments, screenings and clinical referrals.
- Member diagnosis, problem lists and medications.
- Care coordination notes, contacts, referrals or other supports provided.
- All clinical and care coordination notes and contacts from January 1, 2017–June 30, 2017.
- Member plan of care.

- Member's IEP (if applicable).
- Member's Wellness Recovery Action Plan or other recovery planning documents (if applicable).
- Member's advance care directives (if applicable).
- Other notes and documentation that support clinical and social support of member from January 1, 2017–June 30, 2017.
- Other documentation that is related to the PCMH+ program or care coordination supports.

Reviewers included two Mercer representatives who reviewed a total of 20 member files.

B. Member File Review Findings

- CS-HHC uses a comprehensive assessment tool that includes communication, health literacy, digital literacy, physical and BH. The tool is available in both English and Spanish.
- The electronic health record clearly identifies members as PCMH+. The electronic health record integrates physical health-behavioral health; it was evident in the files that both physical health and behavioral health notes were available for review and management of members' health care needs. There is evidence of consistent screening for BH conditions.
- CS-HHC has an internal source of compiled resources for referrals.
- There is evidence of coordination of provider visits, prescriptions, dental, transportation, housing and the use of home visits to reach members.
- Cultural preferences and needs were clearly documented in the medical record.
- While CS-HHC does not use a distinct social determinants of health screening tool or intervention summary, some elements of social determinants of health screening were present.
- When Wellness Recovery Action Plan were found in a member file, goals, objectives, dates to achieve, recovery plan/triggers/action plan, and community supports were collected, and the plan is accessible through the electronic health record to all treating providers.

MEMBER INTERVIEWS

A. Member Interview Process

Healthy, satisfied members are key to the success of the PCMH+ program. The compliance review therefore obtained input from current PCMH+ members and/or their families/designated representatives, focusing on the member's experience with the PCMH+ program; in particular, their experience with PCMH+ care coordination, and their satisfaction with identification of unmet service, social or resource needs.

The PE invited members (and/or their representative) who were assigned specifically to the PE's PCMH+ program to voluntarily participate in an interview designed to solicit their experience with PCMH+ and their care coordinator if they had received PCMH+ care coordination. Mercer requested that priority be given to members who participate on the PCMH+ oversight committee or to members with at least one PCMH+ care coordination contact. Face-to-face interviews with members were preferred with the understanding that the interview team would accommodate members' schedules during the onsite review and conduct phone interviews if necessary.

B. Member Interview Findings

CS-HHC arranged two interviews with PCMH+ assigned members, both in person.

- Both members reported receiving PCMH+ ECC interventions and both said they could easily connect to their ECCs by phone when needed.
- One of the members interviewed participates as a Quality Assurance/Quality Improvement Committee member. The member says she thinks the committee listens to her and believes her role is important because “I have a view outside of the box since I’m a member.”
- Neither member had issues accessing medical care. Both were able to make and attend appointments as needed. One of the members said, “I go to tons of doctors. I get tons of care.” The other loved her pediatrician and said that he “is the best you can find.”
- One of the members stated she would go to her ECC if she had any complaints. The other member was not familiar with how to file a complaint. Both stated they had no complaints with their ECCs or providers or in accessing medical care. The PCMH+ program “is the best thing ever. I tip my hat to you guys for making this connection.”
- Members reported assistance in finding medical specialists, attaining a Hoyer lift, wheel chair, in-home nursing, linking the member with an organization to help with utility payments, and applying for Social Security Disability Income.

APPENDIX A

CORNELL SCOTT-HILL HEALTH CORP. RECOMMENDATIONS FOR IMPROVEMENT PLAN

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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