HEALTH WEALTH CAREER

2018 PCMH+ LEGACY PE DESK REVIEW

SOUTHWEST COMMUNITY HEALTH CARE

JANUARY 4, 2019

State of Connecticut

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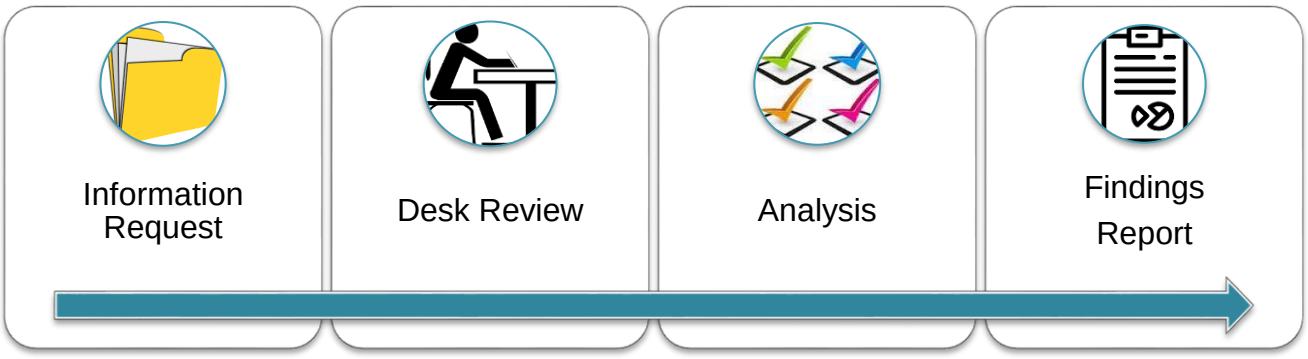
INTRODUCTION

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 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 Southwest Community 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

SOUTHWEST COMMUNITY HEATH CARE PCMH+ PROGRAM OVERVIEW

Southwest Community Heath Care (SWCHC) is a Federally Qualified Health Center serving the Bridgeport area. SWCHC provides an array of primary care and specialist care including; community pediatrics, OB/GYN services, internal medicine, HIV/AIDS, dental care, behavioral health (BH) services and a substance abuse treatment program that includes both outpatient and evening groups. Additional services include community outreach, health education/disease prevention programs and entitlement enrollment services. SWCHC operates six neighborhood service delivery sites, six homeless clinic sites, seven school-based health center sites and one Women, Infant and Children site jointly managed with the Federally Qualified Health Center, Optimus Health Care. SWCHC added a sixth neighborhood service delivery site this year.

SWCHC continues to utilize an “integrated” care team model which works together to enhance the member’s capacity to improve their health. The PCMH+ team consists of five full-time Enhanced Care Coordinators, one more than last year, and SWCHC is seeking to hire another Medical Enhanced Care Coordinator. All Enhanced Care Coordinators are cross-trained; two of the Enhanced Care Coordinators are assigned to members with medical conditions and three Enhanced Care Coordinators focus on members with BH conditions. The Enhanced Care Coordinators hold either a bachelor’s or master’s degree and have health care experience in BH or a medical setting.

Based on an attribution of 7,801 members in Wave 1 of PCMH+ and an attribution of 11,318 members in Wave 2, SWCHC has demonstrated an average penetration rate of 3.2% (an average of 258 unique members per month).

SUMMARY OF PCMH+ PROGRAM IMPLEMENTATION AND PROGRESS TO DATE

A summary of major PCMH+ programmatic and/or operational changes are as follows:

- The Transition Age Youth program has been expanded in 2018. Youth age 16 to 25 years with BH conditions are targeted by the Behavioral Health Enhanced Care Coordinators for transition services. SWCHC is also utilizing resources from the GotTransition.org national resource center.
- SWCHC modified the electronic medical record care management templates utilized by the Enhanced Care Coordinators to enhance the documentation process.
- The referrals module in the electronic medical record has been modified to track external community resource referrals.
- SWCHC has adopted materials from the online resource “The Conversation Project” to aid in advance directive discussions with members and families.

- Routine developmental and BH screening for children was implemented in the Pediatrics Department.

SUMMARY OF PCMH+ PROGRAM SUCCESSES

Community Advisory Board

SWCHC reports successful implementation of the Community Advisory Board with considerable membership drawn primarily from SWCHC PCMH+ attributed members having one or more of the following characteristics:

- Child with special needs
- BH co-occurring diagnosis
- Chronic medical condition
- Disability
- High risk concern
- Transition Age Youth

Community Advisory Board meetings are chaired and co-chaired by the community members and all members have voting privileges.

Transition Age Youth

SWCHC strengthened their Transition Age Youth program to involve multiple care team members, utilization of national transition resource material and integration of the Transition Age Youth care plan into the electronic medical record, which is updated as Transition Age Youth members arrive for consultations. A focus on educating Pediatrics staff around Transition Age Youth issues was also implemented.

Advance Directives

Enhanced Care Coordinators intensified efforts to obtain psychiatric advance directives with SWCHC members. SWCHC adopted The Conversation Project's advance directive materials and forms downloaded in the most common languages of SWCHC's members (English, Spanish and Portuguese) and distributed to members. SWCHC also expanded the endeavor to include medical advance directive education.

SUMMARY OF PCMH+ BARRIERS AND CHALLENGES ENCOUNTERED

SWCHC reported experiencing several programmatic challenges; however, the majority are outside of the scope of this review and included, but are not limited to housing, transportation, lack of access to BH data and inaccurate member phone numbers.

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 Community Advisory Board meetings such that SWCHC demonstrates compliance with the "substantial representation" requirement within PCMH+.	SWCHC has more than doubled member involvement in Community Advisory Boards since the first meeting in September 2017, from three to seven members. Membership has also been enhanced with members drawn mainly from SWCHC PCMH+. Community Advisory Board meetings occur quarterly and are chaired and co-chaired by community members. All members have voting privileges and lunch is provided.	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.	Based on an attribution of 7,801 members in Wave 1 of PCMH+ and an attribution of 11,318 members in Wave 2, SWCHC has demonstrated a penetration rate of 4% (an average of 282 unique members per month).	Met
	Update quality improvement plan to include the PCMH+ program, the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.	SWCHC's Quality Improvement Plan has been updated as of 2017 to reflect the addition of the PCMH+ Program and the Community Advisory Board. The Plan was sent to the Quality Committee of the Board and to the Board of Directors and it was approved in December 2017.	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]
Physical Health-Behavioral Health (PH-BH) Integration	Expand use of Individualized action plans and develop a process to ensure members are provided their Individualized Action Plans and opportunities to update as necessary.	SWCHC documented that all clients in treatment develop a comprehensive treatment care plan with their therapists and psychiatric provider and review the plan at regular intervals. The member file review confirmed that SWCHC continues to use an Individualized Action Plan as the Wellness Recovery Action Plan. The Plan is accessible through the electronic medical record but is not available electronically through the Member Portal. SWCHC is exploring options to allow members to view this document in the Portal. Currently, members are offered a paper copy of the Plan.	Partially Met
	Finalize process to identify Transition Age Youth and development of Transition Age Youth plans of care that address transition needs.	SWCHC has formalized the process to identify Transition Age Youth as individuals age 16 to 25 years with a BH condition. Transition Age Youth are identified in an electronic medical record report and are targeted by the BH Enhanced Care Coordinators for transition services. SWCHC has also developed a transition plan for Transition Age Youth which is identified as a best practice.	Met
Member File Reviews	Develop processes to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record.	SWCHC BH staff discuss psychiatric advance directives with all members in treatment, including the parents of minors, adolescents and adults at the time of the psychosocial evaluation. Advance directives are scanned into members' electronic medical records and advance directive discussions are noted in the care plan. Members declining to engage in advance directive discussions are noted in the electronic medical record.	Met
	Develop procedures to consistently document cultural needs and preferences in the member record.	SWCHC has formalized the process to consistently document cultural needs and preferences in the member record. Cultural needs and preferences include preferred language, spirituality, literacy and learning needs, and how the member identifies their race and ethnicity.	Met

AREA	RECOMMENDATION	DESK REVIEW FINDINGS	SCORE[1]
	Develop procedures to promote universal BH screening for PCMH+ members.	SWCHC formalized procedures to conduct universal BH screening on a routine and at least annual basis on all members. Additionally, staff are required to undergo training regarding the documentation of screenings in the electronic medical record.	Met

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

AREA	OPPORTUNITY	RECOMMENDATION
PH-BH Integration	Members may receive paper copies of their Individualized action plan (the SWCHC's version of Wellness Recovery Action Plans) but these plans are not available through the Member Portal.	Finalize the process to allow members to view the Individualized action plans in the Member Portal.
	Although SWCHC has made efforts to expand the use of Individualized Action Plans, the first quarterly report of 2018 did not indicate any Plans in member files, whereas 1,131 Plans were documented to be in member files at the end of 2017.	Review the data collection procedures for reporting of Individualized Action Plans.

RESULTS

The results of the 2018 desk review indicate that SWCHC has met almost all of the requirements of the recommendations for improvement from 2017. Additionally, SWCHC 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 Member-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 SWCHC continue efforts to complete the process of establishing a Community Advisory Board that includes “substantial representation” within PCMH+. SWCHC has more than doubled Community Advisory Board since the first meeting in September 2017, from three to seven members. Membership has been enhanced with members drawn mainly from SWCHC PCMH+ including a member with co-occurring issues, a member with medical issues, a member with disabilities, a high risk member, and a guardian of a special needs child.
- Community Advisory Board meetings occur quarterly and are chaired and co-chaired by community members. Members are active and all have voting privileges. PCMH+ staff assist with tasks such as taking meeting minutes, reaching out to guest speakers, and providing lunch. SWCHC stresses to PCMH+ members the value of their participation on the Board and to themselves as well — in one instance, a Board member who was the guardian of a child with special needs was connected to an attorney who agreed to work with her at no charge to assist with her child’s school placement. This made a significant impact on the child as well as the guardian.
- SWCHC did not have any recommendations for improvement in the area of staffing. 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. SWCHC has consistently met these requirements. SWCHC 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 review, SWCHC did not have any recommendations for improvement in this area. No underservice was noted during the review. SWCHC had indicated underservice and/or denial of care is prohibited and contrary to their mission and the Health Resources & Services Administration Federal Section 330 requirements and they provided a summary of their process to monitor for underservice.

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 results of the 2017 compliance reviews, it was recommended that SWCHC expand the use of Individualized action plans, which function as the Wellness Recovery Action Plan, and develop a process to ensure members are provided their Individualized action plans and opportunities to update the plans as necessary. SWCHC documented that all clients in treatment develop a comprehensive treatment care plan with their therapists and psychiatric

providers at the time of entry into treatment and reviewed at regular intervals. Individualized goals and objectives are determined by the client with help from the therapist with the goal of stabilization and recovery from addiction, mental health and physical health problems.

- Counts of members with Wellness Recovery Action Plans are monitored through monthly and quarterly reporting. SWCHC consistently provided the number of members who have Wellness Recovery Action Plans in 2017. However, this count did not include obtaining a copy of the plan for the member file, nor are Wellness Recovery Action Plan counts included in 2018 reporting.
- The review of member files demonstrated SWCHC's efforts to develop an Individualized Action Plan with members. The Individualized Action Plan targets key recovery goals and is individualized per member. The plan is accessible through the electronic medical record, but at this time, the plan is not available through the Member Portal. SWCHC is exploring options to allow members to view this document in the Portal and currently provides paper copies to members.
- It was also recommended that SWCHC formalize procedures to promote universal BH screening for PCMH+ members. SWCHC documented that universal BH screening is performed routinely and at least annually on all members seen at SWCHC. The review of member files provided evidence that SWCHC has implemented a consistent process to universally screen members for BH conditions. SWCHC BH screening tools include the Patient Health Questionnaire (PHQ)-2/9, CAGE-AID (a substance use screen), CRAFFT and the Drug Abuse Screening Test (DAST). Since 2017, SWCHC has required staff to undergo training on how to document screenings in the electronic medical record. Screening documentation is monitored and deficiencies are addressed through re-training and supervisory evaluation.
- Another finding from the 2017 compliance review was for SWCHC to develop processes to identify whether a member has a psychiatric advance directive and to develop methods to document or store the psychiatric advance directive in the member record. SWCHC documented that BH staff discuss psychiatric advance directives with all members in treatment, including the parents of minors, adolescents and adults at the time of the psychosocial evaluation. Advance directives are scanned into members' electronic medical records and discussions on the subject are noted on the care plan. Members declining to engage in advance directive discussions are also noted in the electronic medical record.
- To further increase awareness of advance directives, SWCHC downloaded and reproduced "The Conversation Project's" advance directive materials and forms in the most common languages of SWCHC's members (English, Spanish and Portuguese). Enhanced Care Coordinators manned tables with advance directive materials in lobbies of SWCHC's facilities and educated staff and members on the subject. SWCHC also educated on medical advance directives. In 2018, SWCHC participated in the Implementing Palliative Care across the Community Project, a grant-funded project with Fairfield University with the goal of increasing the number of advance directives in the health record. The awareness the program raised and resulted in increased meetings on these subjects, increased staff trainings, and the development of more member-friendly, educational materials. Although SWCHC has expanded efforts to bring awareness of advance directives and member discussions are taking place, SWCHC acknowledged that obtaining completed advance directives from members is still a challenge.

The monthly/quarterly reporting appears to show no advance directives are in any members' files. However, the review of member files supported SWCHC in this area and demonstrated consistent evidence of asking for and/or documenting whether a member has a psychiatric advance directive on file and/or if a member declines.

- The results of the 2017 compliance reviews recommended that SWCHC finalize the process to identify Transition Age Youth and develop Transition Age Youth plans of care that address transition needs. Since the last review, as evidenced by the member file review, SWCHC has successfully developed a transition plan for Transition Age Youth, and this plan is identified as a best practice. SWCHC is also utilizing resource tools from "Got Transition," a national resource to support the medical transition of Transition Age Youth, to assist with the transition planning process. Numerous staff trainings focused on Transition Age Youth have been held since the last compliance review, and Enhanced Care Coordinators utilize internal reports to identify Transition Age Youth for care coordination efforts.
- SWCHC did not have any other recommendations for improvement in this area. Counts of members with BH conditions, the number of BH screenings completed and the number of Transition Age Youth and those with transition care plans and the number of interdisciplinary team meetings held are also monitored through monthly and quarterly reports.

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.
- Expanding development and implementation of the care plan for Transition Age Youth with BH challenges.

B. CYSHCN Findings

- Based on the results of the 2017 compliance reviews, SWCHC did not have any recommendations for improvement in this area.
- The review of member files provided evidence of SWCHC's ability identify and meet the needs of CYSHCN. The member file review demonstrated that SWCHC has a process to obtain and document IEPs and 504 Plans for CYSHCN in the member's file. SWCHC also confirmed coordination with schools when needed and attendance in special education meetings to assist families with education advocacy.

- Numerous staff trainings focused on CYSHCN have been held since the last compliance review and Enhanced Care Coordinators utilize internal reports to identify CYSHCN for care coordination efforts.
- Counts of CYSHCN and documentation of IEPs and 504 Plans also are monitored in monthly and quarterly reporting. Based on this reporting, SWCHC has consistently demonstrated the ability to flag CYSHCN and report on the number of members with IEPs or 504 Plans in the electronic medical records.

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, SWCHC did not have any recommendations for improvement in this area. Disability trainings have been held for staff since the 2017 including a Department of Developmental Services in-service, special education family support training and a webinar on the Disability-Competent Care Self-Assessment Tool. Also, a member with disabilities was recruited as a member of the Community Advisory Board.
- Counts of members with disabilities are monitored in monthly and quarterly reporting. SWCHC noted that it is difficult to track adjusted appointment times for members with disabilities although SWCHC maintains that the electronic medical record does allow staff to adjust appointment times for members who require more time.

A. Cultural Competency Requirements

Incorporating a member's cultural preferences and acknowledging that culture can expand beyond language and ethnicity is a key tenet of the PCMH+ program. Cultural sensitivity can help inform care coordination and other service interventions to better assist the member, particularly with regard to social determinants of health (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 review, it was recommended that SWCHC develop procedures to consistently document cultural needs and preferences in the member record. SWCHC reported that all SWCHC staff are required to undergo cultural competency training, including training on how to document cultural needs and preferences in the electronic medical record. Other recent trainings include transgender health and LGBT health education. The review of member records confirmed that cultural preferences are collected and are part of the member files including preferred language, spirituality, literacy and learning needs, and how the member identifies their race and ethnicity. SWCHC noted that Enhanced Care Coordinators ask members questions pertaining to cultural needs and preferences, and this was also consistently documented in the chart review. SWCHC notes that any issues relating to appropriate documentation by staff are addressed through re-trainings and supervisory evaluation.

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, SWCHC 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, SWCHC has continued to maintain 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, SWCHC's resource list included organizations providing services such as housing, food assistance, employment, transportation, utility bill assistance, mental health and addiction, and HIV/AIDS services.

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 Individualized Education Programs 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 17 member files.

B. Member File Review Findings

- SWCHC continues to utilize NextGen® as their electronic medical record. All care team members have access to the electronic medical record, and may make referrals across disciplines.
- SWCHC continues to utilize a Care Management Plan or Member Plan to document member needs, goals and referrals. The care management plans identified unmet SDoH (if applicable) and steps taken by the Enhanced Care Coordinator to assist with addressing needs.
- SWCHC has implemented a consistent process to universally screen for BH conditions. Screening tools include the PHQ-2, PHQ-9, CAGE Alcohol Screening, CRAFFT and the Drug Abuse Screening Test.
- SWCHC provided consistent evidence of asking for and/or documenting if a member has a psychiatric advance directive on file. This is documented under the “Advance Directives” tab in the health record.
- SWCHC continues to use an Individualized action plan as the Wellness Recovery Action Plan. The Individualized action plan targets key recovery goals and is individualized per member. The plan is accessible through the electronic medical record.
- For Children with Special Health Care Needs, SWCHC has a process to obtain and document IEPs or 504 Plans in the member’s file. SWCHC also demonstrates coordination with schools when needed and will attend special education meetings to assist families with education advocacy.
- SWCHC has developed a transition plan for Transition Age Youth which is identified as a best practice. The plan outlines the member’s health conditions and special health care needs, access to resources, current educational status (including if an IEP or 504 Plan is in place), employment status, personal goals, healthy activities, care needs (such as ability to complete activities of daily living), housing needs, transportation needs, social supports, if a key decision-maker or guardian is in place, if the member wants to engage in advance care planning or if advance directives are in place or desired. The plan also includes an action plan with goals, steps and timeframes for completion.
- SWCHC is also utilizing resource tools from “Got Transition,” a national resource to support the medical transition of Transition Age Youth, to assist with the transition planning process.
- Cultural preferences, such as preferred language, religion, and how the member identifies their race and ethnicity were evident in the member files. SWCHC also consistently indicates if cultural needs or preferences are identified by the member. This information, along with any health literacy needs, is found on the “Departmental TDL” tab under “Counseling/Educational Factors.”

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	SWCHC has not completed the process of establishing a Community Advisory Board that includes substantial representation by PCMH+ members as well as one participating provider assigned to SWCHC.	Develop a plan to recruit and retain sufficient PCMH+ members to participate in the Community Advisory Board meetings such that SWCHC demonstrates compliance with the "substantial representation" requirement within PCMH+.
	Enhanced care coordination member penetration rates are low, but steadily improving, for the 7,801 assigned PCMH+ membership. SWCHC reports the following monthly care coordination contacts: April 2017: 0 contacts; May 2017: 57 contacts; June 2017: 172 contacts; July 2017: 202 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.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	SWCHC's quality improvement plan does not include annual goals, mention of the PCMH+ program, identification of the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.	Update quality improvement plan to include the PCMH+ program, the oversight body responsible for PCMH+ program oversight or how the PCMH+ program is evaluated.
PH-BH Integration	Individualized action plan implementation was limited as of the time of the review and members were not being provided their recovery plan when completed.	Expand use of Individualized action plans and develop a process to ensure members are provided their Individualized action plans and opportunities to update as necessary.
	SWCHC is building processes to identify Transition Age Youth and will be leveraging their existing plan of care to build transition plans that address linkages to adult services beyond medical services within SWCHC.	Finalize process to identify Transition Age Youth and development of Transition Age Youth plans of care that address transition needs.
Member File Reviews	There was inconsistent evidence of asking for and/or documenting if a member has a psychiatric advance directive.	Develop processes to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record.
	There was inconsistent evidence of collecting cultural needs and preferences.	Develop procedures to consistently document cultural needs and preferences in the member record.
	There was inconsistent evidence of universal BH screening.	Develop procedures to promote universal BH screening for PCMH+ members.

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