

HEALTH WEALTH CAREER

PCMH+ WAVE 2 COMPLIANCE REVIEW

WHEELER TORRINGTON
ADVANCED NETWORK

MAY, 2019

State of Connecticut

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INTRODUCTION

The Person Centered Medical Home Plus (PCMH+) program was launched on January 1, 2017 as part of the Connecticut Department of Social Services (DSS) investment in value-based purchasing care coordination. PCMH+ provides person-centered, comprehensive coordinated care to HUSKY members. PCMH+ builds on the success of Connecticut Medicaid's Person-Centered Medical Home (PCMH) program which works to improve quality of care and the overall health of HUSKY members. PCMH+ Wave 2 launched on April 1, 2018 after the successful completion of Wave 1. PCMH+ Wave 2 will build on both the existing PCMH program and PCMH+ Wave 1 by focusing on Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, provider competencies to support Medicaid members with complex medical conditions and disability needs, and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits. DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the PCMH+ program and conduct reviews of PCMH+ Participating Entities (PEs).

PCMH+ is a shared savings model where PEs that meet identified benchmarks on quality performance standards and under-service prevention requirements, while reducing Medicaid expenditures and improve HUSKY member health outcomes may share in a portion of program savings. Quality measure scoring and PCMH+ program savings calculations for Wave 2 will be conducted in Fall 2019 and, therefore, are not evaluated as part of this PCMH+ compliance review. This review focuses solely on evaluating PCMH+ PE compliance with PCMH+ Wave 2 program requirements, identifying best practices and opportunities for improvement.

PCMH+ PROGRAM REQUIREMENTS

The PCMH+ program provides care coordination services to all PCMH+ assigned members through a set of required Enhanced Care Coordination interventions. For PEs that are Federally Qualified Health Centers (FQHC), there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice. The following table provides a high-level summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are located in Section 3.

PROGRAM OPERATIONS	ENHANCED CARE COORDINATION	COMMUNITY LINKAGES
<ul style="list-style-type: none"> • Current participant in DSS' PCMH program • Operate an oversight body with substantial participation by PCMH+ members • Identify a PCMH+ senior leader and clinical director • Employ sufficient and qualified staff to provide enhanced care coordination services • Submit monthly reporting to DSS • Develop a planned approach to monitor, identify and address under-service 	<ul style="list-style-type: none"> • Physical Health (PH)–BH Integration • Children and Youth with Special Health Care Needs (CYSHCN) • Competencies in Care for Individuals with Disabilities • Cultural Competency 	<ul style="list-style-type: none"> • Implement or enhance contractual relationships or informal partnerships with community partners to impact social determinants of health (SDoH) • Sponsor local community collaborative forums or participate in existing forums • Demonstrate results of engaging in partnerships with community partners

REVIEW METHODOLOGY

The PCMH+ Wave 2 compliance review assessed for compliance, quality and effectiveness in achieving the goals of the PCMH+ program for the period between June 2018 to February 2019 and was organized into five phases presented in the diagram below:



Information Request — January 2019

Mercer submitted an information request to each PE in January 2019. The information request solicited a variety of documents and materials in an effort to gain an understanding of PE's program compliance, operations, and approach in implementation of PCMH+. The information request included but was not limited to member files, organizational charts, PCMH+ staffing, policies and procedures, narrative responses, underservice policy, and other relevant information related to the implementation of the PCMH+ program. PEs were also asked to complete a program questionnaire.

Desk Review — February 2019

Mercer received information electronically from the PEs and conducted a desk review of all submitted material. Areas where Mercer could not determine if a process or procedure was compliant with PCMH+ program standards were noted for follow-up discussion during onsite review.

Onsite Review — March 25, 2019

The onsite review for Wheeler Torrington occurred on March 25, 2019, at the Community Health and Wellness Center (CHWC) 469 Migeon Avenue Torrington, Connecticut. The onsite review began with an introductory session with the DSS staff, the Mercer team and CHWC leadership and PCMH+ dedicated staff. As part of the introduction, CHWC presented a PCMH+ program implementation overview. Mercer and DSS conducted interviews with CHWC staff focusing on: PCMH+ Program Operations, Enhanced Care Coordination, Community Linkages and Member Interviews. CHWC staff interviews included:

- Susan Walkama, President and CEO, Wheeler Clinic, PCMH+ Co-lead
- Joanne Borduas, CEO, CHWC, PCMH+ Co-lead
- James Chowaniec, IT Manager, CHWC
- Michelle Brady, Director of Nursing, CHWC
- Amy Begnal, Operations Manager, CHWC
- Sabrina Trocchi, COO, Wheeler Clinic
- Jean Marie Monroe-Lunch, Senior Director ADP, Wheeler Clinic
- Keturah Kinch, Director, Community Engagement, Wheeler Clinic
- Nic Scibelli, Chief Transformation and Information Officer, Wheeler Clinic
- Bill Kania, Director, Children's Operations, Wheeler Clinic
- Erica Buss, Director of Quality/Infection Control, Wheeler Clinic
- Lisa Roth, Director of Care Management, Wheeler Clinic
- Heidi Joseph, VP Health and Wellness Operations, Wheeler Clinic

Analysis and Findings Report — May 2019

During all phases of the Wave 2 onsite compliance review, information was gathered and a comprehensive review was completed. Results of the comprehensive review is the basis for this report.

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SUMMARY OF FINDINGS

WHEELER TORRINGTON PCMH+ PROGRAM OVERVIEW

The Wheeler Torrington Advanced Network (AN) is a partnership between two Federally Qualified Health Clinics (FQHC) Wheeler Clinic (WC) and Community Health and Wellness of Greater Torrington (CHWC). The partnership is new and unique to the PCMH+ program representing the first Advanced Network comprised exclusively of two FQHCs. The Wheeler Torrington AN is developing processes to fully implement PCMH+ requirements universally across all sites. This report identifies differences between the two FQHCs by naming the FQHC associated with findings related to only one and not both FQHCs. Findings associated with both FQHC's will apply to the PCMH+ Advanced Network.

The Wheeler Torrington AN includes five locations: WC in Hartford, New Britain, Bristol and CHWC in Torrington and Winsted. The AN provides a lifespan of medical, BH, dental and specialty services including women's health, nutrition, geriatrics, laboratory, a demonstration kitchen, chiropractic care, alternative medicine, HIV and infectious disease care, ophthalmology, chronic disease management, prevention and social services. Additional services include seven school-based clinics, a senior center and a shelter location. Plans are in development to open an additional school-based clinic and office in Waterbury.

WC employs seven community health workers, six registered nurse (RN) care coordinators and three care facilitators including one with medication-assisted treatment (MAT) specialty. CHWC employs four care coordinators, one BH specialist and two community health workers. The AN uses Community and Clinical Integration Program (CCIP) funding to hire and train community health workers who live within the communities they serve. The AN hires certified peer specialists experienced in providing support to those dealing with addiction and gambling disorders. If peer specialists are not certified, the AN provides the employee with supports in obtaining their certification. Bilingual staff primarily speak Spanish, and a dentist speaks Polish which is commonly spoken in the area served by the AN.

The PCMH+ program is co-led by the CEOs of WC and CHWC. Each clinic has a medical director to oversee all clinic activities. The nurse care managers at WC and CHWC are the clinical leads of the care plan and ensure integration and coordination of services. The CEOs also co-chair the AN's oversight committee. The oversight body meets monthly and reports to the quality committee of Wheeler clinic's board of trustees.

The AN provides care coordination for 3,392 PCMH+ members. The AN reports an average penetration rate of 1.9%. The penetration rate is based on the number of unique member contacts per month divided by the assigned PCMH+ membership. Since start of Wave 2, the AN has reported the following unique member contacts per month: June 2018: 78 members; July 2018: 75 members; August 2018: 68 members; September 2018: 59 members; October 2018: 57 members; November 2018: 54 members; December 2018: 71 members; January 2019: 81 members and February 2019: 59 members. The AN's care coordinators average 6.3 care coordination contacts per month. It is important to note that a ramp-up period is typical for newly implemented programs.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	The AN has established strong clinical teams, including community health workers who live in the communities they serve.
Under-Service	The AN reviews the number of providers and monitors panel size and balance member distribution. Significant efforts are made to engage members in treatment, including offering walk-in appointments and using patient greeters located in the clinic waiting rooms.
Physical Health-Behavioral Health Integration	The AN screens universally for depression using the Patient Health Questionnaire (PHQ)2/PHQ9 and the AUDIT-C and CAGE- AID for substance abuse. Other tools that were identified for use include the Child PTSD Symptom Scale (CPSS), Trauma History Screen, Ohio Scales, gambling screening and assessment and the Pediatric Symptom checklist. All screening tools used are captured in the electronic medical record (EMR) for reference and to monitor changes and trends with repeat screenings.
	The WC BH intake is comprehensive, and includes questions about community supports/leisure/recreational/religious activity, self-help programs and groups, family supports and participation in treatment. The BH intake also captures the member's cultural practices and preferences that assist care teams in planning care, treatment, and other member services.
	WC has an established process to ask members about advance directives and to obtain a copy for the member file.
	WC incorporates Wellness Recovery Action Plans into the member's plan of care.
	The AN is using evidenced-based practices in family medicine and BH including cognitive behavioral therapy (CBT), trauma informed treatment and acupuncture for pain and addiction.
Competencies in Care for Individuals with Disabilities	The AN has established detailed procedures to identify or flag members with disabilities in the EMR. The AN also has processes in place to document the unique needs of members with disabilities such as durable medical equipment and accommodations needed in the clinical environment.

REVIEW AREA	STRENGTH
Cultural Competency	The AN requires cultural competency training upon hire and then annually. Training is offered and tracked through the RELIAS system, a web-based training program.
	WC completed a year-and-a-half process to become compliant with the Office of Minority Health’s (OMH’s) culturally and linguistically appropriate services (CLAS) standards prior to becoming part of the PCMH+ program. One component of this is the implementation of a practice of providing a culturally-based performance goal for all employees.
	The AN certifies bilingual staff and pays a differential for linguistic competency.
Community Linkages	The AN screens all members for SDoH and includes the findings in the EMR. The screening occurs in both PH and BH settings. CHWC has been using the Protocol for Responding to and Assessing Patient Assets, Risks and Experience (PRAPARE) Smart Form since January 2018 and WC uses a similar tool.
	The AN utilizes a “basic needs” fund to support members in managing SDoH and to promote healthy outcomes. The fund covers expenses that for which there are no other resources (e.g., car repairs).

OPPORTUNITIES FOR IMPROVEMENT

The table below represents the opportunities for improvement identified during the desk and onsite review process. A detailed “Recommendations for Improvement Plan” can be found in Appendix A of this report.

Please note that identification of CYSHCN and members with disabilities posed challenges for many of the PEs and therefore, the challenges identified at this PE are not unique. DSS recognizes that the definitions for these populations vary and identification of these members is new for PEs under the PCMH+ program. As such, DSS will continue to provide technical assistance to assist the PEs to meet the requirements of PCMH+ for these specialty populations.

REVIEW AREA	OPPORTUNITY
Program Operations	The AN is continuing recruitment efforts to increase PCMH+ member participation on their advisory boards.
	The AN has demonstrated a low penetration rate of 1.9% with approximately six care coordination contacts per month per care coordinator.
	Starting in April 2019, the AN will begin submitting separate monthly reports for each FQHC. The separation of data will allow for improved analysis of implementation of the PCMH+ program at each FQHC.
	CHWC has separate PH and BH charts and members of the care team do not always have access to all member information. WC’s EMR is fragmented without templates or a specific documentation protocol which makes it difficult to easily review the member information.

REVIEW AREA	OPPORTUNITY
Physical Health- Behavioral Health Integration	CHWC is developing processes to document if a member has a psychiatric advance directive and methods to include this in the member's file.
	CHWC is developing processes to engage with members about Wellness Recovery Action Plans or other recovery planning tools. The current plan of care contains some aspects of recovery, but should be expanded to be considered a recovery-based tool.
	WC does not begin transition planning before age 18.
	The AN is developing standardized documentation processes for transition-related discussions for Transition Age Youth.
Children and Youth with Special Health Care Needs	The AN is developing processes regarding advance care planning with CYSHCN.
	The AN is developing processes to obtain Individualized Education Plans (IEPs) and 504 Plans from the schools.
Competencies in Care for Individuals with Disabilities	The AN is developing standardized documentation standards regarding adjusted appointment times for members with disabilities.
	The AN has not yet implemented disability competency training.
Cultural Competency	The AN does not include cultural needs and preferences in plans of care.
Community Linkages	The AN does not always clearly document care coordination efforts or demonstrate when an identified SDoH was resolved.

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DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

PCMH+ Program Operations Requirements

PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from the Joint Commission. Additional program requirements include:

- Operate an oversight body with substantial participation by PCMH+ members
- Identify a PCMH+ senior leader and clinical director
- Employ sufficient and qualified staff to provide enhanced care coordination services
- Submit monthly reporting to DSS

PCMH+ Program Operations Findings

- The AN has established separate oversight bodies for WC and CHWC. Both are continuing to focus on recruiting members to improve attendance and representation. WC has met three times since implementation of the PCMH+ program. The meeting is held at one location and transportation is offered for the members from the other sites so that they can participate in person. Recruitment efforts include engaging members while onsite at the clinic, via existing committee members and through clinic staff referral. Activities are offered for children and meals are provided. Member ideas are included on the next agenda by soliciting them at the end of the meeting. CHWC has been holding monthly Patient and Family Advisory Board meetings at their main site. This board functions as CHWC's advisory body. Currently there are three members with a goal of having at least 20 members. Recruitment efforts are similar to WC and lunch is also provided.
- In addition to separate advisory bodies administered at each FQHC, the AN has established a steering committee (advisory body), which includes representation from both FQHCs. The AN plans to involve members on the steering committee once the members are more established in their roles on the FQHC-specific advisory boards. The goal is also to have 51% consumers on each board.
- The AN has assigned a senior leader and medical director to each FQHC who provides oversight and clinical leadership for the PCMH+ program.

- WC employs seven community health workers, six RN care coordinators and three care facilitators, including one with MAT specialty. Each care team may also include medical/psychiatric/dental providers, BH clinicians, medical assistants, RNs, LPNs, chiropractors, nutritionists and a MAT team.
- CHWC employs four care coordinators, one BH specialist and two community health workers. Each care team may also include medical/psychiatric/dental providers, BH clinicians, medical assistants, RNs, LPNs, chiropractors, nutritionists and a MAT team. CHWC has formed a primary care management team which includes a focus on how to include community health workers in the care.
- The AN reports a low penetration rate of 1.9%. The AN's care coordinators average 6.3 care coordination contacts per month.
- The AN submits the monthly report on a timely basis each month. Starting in April 2019, the AN will begin submitting separate monthly reports for each FQHC. The partnership between WC and CHWC is new and unique to the PCMH+ program as the two FQHC's have formed one Advanced Network. Each FQHC is developing processes to fully implement PCMH+ requirements universally across the Advance Network, and the separation of data will allow for improved analysis of PCMH+ program implementation.
- CHWC PH and BH charts are not integrated and the care team does not have access to the entire EMR. Information is shared through telephone calls between care team members or by granting temporary access to the electronic record.
- The WC EMR also lacks specific documentation protocols or templates. Most patient information is contained within the history section of the record, and not immediately accessible to the care team. This creates a challenge in identifying member needs.

UNDER-SERVICE

Under-service Requirements

In order to ensure that savings within the PCMH+ program do not result from limitations on members' access to medically necessary services, or members with complex care needs are not removed from a PE's practice for reasons associated with high-cost. Requirements include:

- Develop a planned approach to monitor, identify and address under-service. The approach must be designed to monitor and identify potential underservice utilization or inappropriate reductions in access to medically necessary care that includes prohibiting these practices and educating staff.

- PEs will be disqualified from receiving shared savings if they demonstrate any or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.

Under-service Findings

- The AN policy “MPC CM 16 Care Coordination” includes a section on an under-service utilization monitoring strategy which indicates they will monitor and prevent under-service utilization through use of data analytics and peer reviews of care provided.
- CHWC monitors no show appointments and the productivity of the providers. Provider panels are evaluated on a quarterly basis. Clients seen in the walk-in clinic are assigned a provider. They also hired a waiting room greeter to engage with clients, conduct member satisfaction surveys, and screens for SDoH. Complaints and grievances are also reviewed.
- WC monitors the ratio between providers and panel size so that no one provider has a disproportionate number of acute clients. Community health workers also engage with members and serve as an advocate to assess satisfaction, assist with complaints and grievances, and screen for SDoH.
- All patient requests to change providers are reviewed to determine if there is an issue with a provider as the reason for the patient request; and if that issue needs to be addressed.
- The desk and onsite review conducted by Mercer did not detect under-service.

ENHANCED CARE COORDINATION

PH-BH Integration Requirements

Requirements for PH-BH integration align with the goals of the PCMH+ program. PCMH+ PH-BH requirements include:

- Use of standardized tools to expand BH screenings beyond depression.
- Promote universal BH screening across all populations, not just those traditionally identified as high risk.
- Obtain and maintain a copy of psychiatric advance directives in the member file.
- Obtain and maintain a copy of a member’s Wellness Recovery Action Plan in the member file.
- FQHCs only: Employ a care coordinator with BH experience who serves as a member of the interdisciplinary team and has the responsibility for tracking members, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.

- FQHCs only: Expand development and implementation of the care plan for Transition Age Youth with BH challenges.
- FQHCs only: Develop Wellness Recovery Action Plans or other BH recovery planning tools in collaboration with the member and family.
- FQHCs only: Use of an interdisciplinary team that includes BH specialists, including the required BH Care Coordinator.

PH-BH Integration Findings

- The AN screens for depression using the PHQ2/PHQ9 and the AUDIT-C and CAGE- AID for substance abuse. Other tools that were identified for use include the CPSS, Trauma History Screen, Ohio Scales, gambling screening and assessment and the Pediatric Symptom Checklist. All screening tools used are captured in the EMR for reference and to monitor changes and trends with repeat screenings. Additionally, the AN has consistently reported on the number of members screened for BH conditions on the monthly report.
- WC has an integrated protocol for the initial assessment and care planning for new patients. This includes the use of a standardized biopsychosocial assessment tool that assesses needs related to BH, substance use and medical conditions. Screening tools are embedded within the assessment including the Modified Mini, Global Appraisal of Individual Needs-Short Screener (Gain SS), Daily Living Activities (DLA-20), and the Mental Health Computerized Adaptive Testing. Each member that enters care at WC has an individualized action plan (IAP). WC also has a document to guide treatment planning and there are expectations to use the results of any screening tool or instrument to form treatment plan goals and objectives.
- WC has open access to BH services, including walk-in availability or integration of a member following a positive BH screen.
- WC's BH intake is comprehensive. It includes questions about community supports/leisure/recreational/religious activity, self-help programs and groups, family supports and participation in treatment. BH intake also captures the member's cultural practices and preferences to assist care teams during care planning, treatment, and to identify appropriate member services.
- CHWC offers a hybrid BH model. They will accept walk-in appointments but will triage for acute level of needs to determine if the person needs to be seen immediately or can be scheduled for an appointment.
- WC offers MAT in primary care settings that are all Suboxone and Vivitrol certified. CHWC coordinates this treatment option with community MAT programs, but also offers some services in-house.

- WC has an Advance Directives protocol and at intake all clients are asked if they have a medical and/or psychiatric advance directive. Existing copies of the directive is placed in the member's chart. If no directive exists, members are educated on the importance of advanced directives and offered information and supports in the completion of a directive.
- CHWC is developing processes to engage members about psychiatric advance directives.
- WC incorporates Wellness Recovery Action Plans into the plan of care. There was evidence of Wellness Recovery Action Plans in the member file review which were accessible to the entire clinical team. The plans included integrated PH and BH goals which were written the member's own words.
- CHWC does not specifically have a Wellness Recovery Action Plan and serve a small number of BH members; although, WC's care plan is inclusive of Wellness Recovery Action Plan components and could be expanded to include more recovery-focused content. RNs work to develop integrated care plans and conduct bi-monthly meetings with the Advanced Practice Registered Nurses (APRNs) regarding Wellness Recovery Action Plan and incorporation of WRAPs into the EMR template.
- WC RN care managers work with Transition Age Youth beginning at age 18. Activities can include re-signing releases and consents, arranging for a warm handoff to an adult provider, coordinating with local mental health agencies who may offer supports like vocational training or supervised living. They also interact with group homes and schools around transition needs.
- CHWC reports they have not served many Transition Age Youth with BH needs. For Transition Age Youth with PH needs, members are assigned to a nurse at age 16 who assists with the transition to adult services. It should be noted, that most members in this category do not have a pediatric provider but are seen by an APRN who provides care to the member and their families.
- Files for members identified as Transition Age Youth generally did not address discussions related to transitioning from pediatric care to adult services. There was some evidence in WC's EMR that transition discussions were happening, but it was difficult to find any information in the file pertaining to a warm hand-off if the member was transitioned to an adult provider.
- The AN is using evidenced-based practices in family medicine and BH including CBT, trauma informed treatment and acupuncture for pain and addiction.
- The AN's EMR allows for extraction of BH data and the AN has consistently reported on all BH data points in the monthly report.

Children and Youth with Special Health Care Needs Requirements

CYSHCN and their families often need services from multiple systems — health care, public health, education, mental health and social services. PCMH+ requirements include:

- Require advance care planning discussions for CYSHCN.
- Develop 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.

Children and Youth with Special Health Care Needs Findings

- The AN serves a small pediatric population. In February 2019 there were 3,392 total members and 317 were in the CYSHCN category. WC did recently acquire a pediatric clinic staffed by a pediatrician and a APRN, but reports their pediatric population is also small.
- The AN utilizes the Maternal Child Health Bureau's definition of CYSHCN which states: Children and youth between 0–17 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.
- Advanced care planning discussions do not occur regularly since many youth with high needs are seen by specialists and already have a plan in place. The AN uses global alerts and sticky notes in the EMR to identify special health care needs. The AN acknowledges it can be challenging to engage members in care plan conversations and see this as an area of potential growth.
- The AN reported they have a process in place to ask parents about special education needs and/or plans during PH or BH visits. If an IEP or 504 Plan exists, the parent is asked to sign a release so the plan can be obtained, placed in the chart, and used as part of the care planning process.
- The AN reports challenges in getting IEPs and 504 Plans from the schools; although there is more success in schools where the AN runs integrated school-based clinics. Challenges include an overall lack of communication with schools and the AN indicates they are working to increase trust between the schools and clinics by attending meetings, offering trauma informed training, and improving collaboration through email communication.
- The AN's EMR allows for extraction of data pertaining to IEPs and 504 Plans and has consistently reported this on the monthly report.

Competencies Caring for Individuals with Disabilities Requirements

PCMH+ requirements for individuals with disabilities pertain to include:

- Expand the health assessment to include questions about: Durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.
- Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.
- Develop and require mandatory staff disability competency trainings to address the care of individuals with physical and intellectual disabilities.
- Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam tables) and communication adaptive equipment.
- Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment).
- Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).

Competencies Caring for Individuals with Disabilities Findings

- The AN uses a broad definition to identify members with disabilities and includes members with physical, intellectual, developmental and or BH needs. They also include individuals who have a physical or mental impairment that substantially limits one of more major life activities, a history of such impairment or perceived by others to have such an impairment.
- WC indicated that the list of diagnostic codes used to identify members with disabilities was updated, resulting in a significant increase in identified patients.
- CHWC uses global patient alerts in the EMR to identify unique needs of members with disabilities. Durable medical equipment (DME) need is routinely documented and the preferred vendor, pharmacy, and a “circle of care” which lists all of the providers involved in the member's care. The EMR includes structured data fields, which identify the member needs.
- WC EMR displays orders for DME, and also includes a problem list that would include the need for adaptive equipment including wheelchairs, interpreters, hearing aids and eyeglasses. Sticky

notes and pop up alerts are used in the EMR to flag special needs. Huddles and interdisciplinary team meetings are used to discuss specific needs and member accommodations.

- The AN offers extended visits when necessary, such as when there are mobility issues or when the language line is needed. On the monthly report, the AN has reported 108 PCMH+ members with disabilities who had adjusted appointment times, but reviewers could not find evidence of documented adjusted appointment times in the member files.
- The AN did not show evidence of providing disability competency training. CHWC is considering bringing in a trainer to provide disability-related content, including addressing desensitization.
- The AN reports that all of its health center locations are fully compliant with the Americans with Disabilities Act. Sites offer electric beds, wheelchairs and other accommodations such as mobility and physical site navigation for individuals with visual impairments.
- CHWC collects the educational level of the client to help identify the level of health literacy. The client materials are written at a fourth grade reading level. Written instructions are given to clients but also reviewed verbally. Clinic signs are also in braille.
- WC assesses health literacy and asks the client about their preferred learning method. Written materials can be adjusted to increase the font and modify the language.
- The AN's EMR allows for extraction of data pertaining to members with disabilities and the AN has consistently reported on these data points on the monthly report.

Cultural Competency Requirements

PCMH+ program Cultural Competency requirements include:

- Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.
- Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.
- Compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

Cultural Competency Findings

- The AN requires cultural competency training upon hire and then annually. Training is offered and tracked through a web-based training program, RELIAS.
- WC also completed a year-and-a-half process to become compliant with CLAS standards prior to becoming part of the PCMH+ program. Implementation required culturally-based performance goals for all employees. Culturally based goal examples include; working to implement

programmatic changes, working with LGBTQ members, Haitian or Puerto Rican cultural training, and human trafficking.

- WC's BH intake includes a specific question asking if there are cultural practices and preferences that should be considered when planning care, treatment or services.
- CHWC gathers information on the registration form that includes gender identity, sexual orientation, race, ethnicity, military status, housing status, agricultural status (e.g., seasonal or migrant worker) and preferred language. WC uses a form that includes the same information except agricultural status, but includes religion.
- Staff were able to cite specific examples of cultural preferences they have encountered and addressed directly with members but none of the member files reviewed included cultural preferences in the care plans.
- Cultural preferences related to food/nutrition were identified as a common need that should be addressed in treatment; particularly for members who are overweight or require a special diet. CHWC reported holding community events, grocery store tours, and cooking demonstrations. WC identified examples of meeting members in the grocery store to review food choices.
- WC currently supports a diversity and inclusion committee to promote and monitor equity, diversion and inclusion for members and staff. CHWC is in the process of forming a committee.
- The AN certifies bilingual staff and pays a differential for linguistic competency. Currently there are 28 bilingual staff with the primary language being Spanish. WC also has a dentist who speaks Polish, a common language found in the area served by WC. Written materials are available in English and Spanish. The AN also uses language lines and has access to sign language interpreters. The AN employs a diverse workforce and attempts to hire staff who are representative of the patient population. .

COMMUNITY LINKAGES

Community Linkages Requirements

In an effort to meaningfully impact SDoH, promote physical and behavioral health integrated care, and assist members in utilizing their Medicaid benefits, community linkage requirements include:

- Implement and enhance contractual relationships or informal partnerships with local community partners. Community Partnerships will meaningfully impact social determinants of health, promote physical and behavioral health integrated care, and facilitate rapid access to care and needed resources.
- Sponsor local community collaborative forums or participate in existing collaborative forums to develop broader understanding and partnerships between health providers and community resource agencies.

- Demonstrate the results of engaging in partnerships, available access for members to various types of medical and non-medical services and observations regarding the potential short-term and long-term impacts on members.

Community Linkages Findings

- The ANs report that all members are screened for SDoH and findings are included in the EMR. Screenings take place in both the PH and BH setting. Members are screened initially, annually, and when a change is noted or an event happens such as an emergency room visit. Results of the member file review indicate that most members are screened for SDoH, but not all.
- When CHWC identifies a member with a SDoH need, they attempt to have a community health worker meet with the member immediately. If that is not possible, the community health worker contacts the member via telephone. When WC identifies a SDoH, there is communication between the care facilitators and the care manager to connect with the member and address the need. It was difficult to determine through the member files reviewed if members received care coordination services related to SDoH and if the SDoH was adequately addressed.
- CHWC has been using the PRAPARE Smart Form since January 2018. CHWC clinic greeter screens members in the waiting room, and they have developed a script when asking the questions. The script has been effective in identifying member needs and has been shared with network providers. CHWC has a community champion who builds relationships with community services and helps to maintain a spreadsheet of available resources. The list features SDoH community resources by town including: Housing, vocational, emergency safety housing, transportation, food pantry, cash assistance. CHWC also utilizes Connecticut 211.
- WC has a similar SDoH form which identifies financial needs, educational level, stress, depression, physical activity level, alcohol use, social connection and exposure to violence. They are considering the use of PRAPARE. WC uses a spreadsheet to track available community resources managed by one community health worker. WC's partnerships include: Elder serving resources, housing, child serving resources, food, transportation, parenting support. WC also uses Connecticut 211.
- The AN utilizes a "basic needs" fund totaling approximately \$200,000. The fund is used to fill in gaps to other community resources that will lead to positive health outcomes. Funds have been used to address transportation issues including car repairs and cab fare so members can make appointments. Funds have also been used to purchase a new mattress for a member with asthma.
- AN staff are oriented to member education resources during the new hire onboard process and trainings include referral resources for community linkages that address SDoH.

MEMBER FILE REVIEW PROCESS

PEs were instructed to provide 30 of the following member files:

- 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 and have received care coordination in the review period.
- Five files representative of PCMH+ members who are a CYSHCN and have received care coordination in the review period.
- Five files representative of PCMH+ members who the PE identifies as having a disability and have received care coordination in the review period.
- Five files representative of members who have been linked to community resources to address SDoH in the review period.
- 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 a member with a BH condition or a member with a disability.
- Three members who have refused care coordination services. 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 SDoH.

PEs were instructed to include the following in each member file:

- A demographic description or demographic page, which should include at a minimum: member name, member ID, date of birth, gender and preferred language.
- A diagnosis list.
- The most recent member assessment, including an assessment of SDoH.
- 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.
- Care coordination progress notes, including, but not limited to, referrals to community resource agencies that address SDoH for the specified timeframe. PE was asked not to submit physician or practitioner progress notes unless the notes includes coordination with or acknowledgement of care coordination activities.

- Results of most recent BH screening(s).
- 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.
- Copy of Wellness Recovery Action Plans or other recovery tool (if applicable to the member).
- Transition Age Youth transition plan of care (if applicable to the member).
- Evidence of advance care planning discussions or care plans for CYSHCN (if applicable to the member).
- 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.
- Other documentation the PE believes is relevant to the review process and demonstrates compliance with PCMH+ requirements.

Reviewers included two Mercer representatives; one who reviewed all of the files and another who reviewed 15. While onsite, Mercer requested a secondary review of eight charts, which were reviewed by one Mercer staff and one DSS representatives who reviewed a total of eight member files.

MEMBER FILE REVIEW FINDINGS

General Findings

- The AN submitted 30 member files; one file contained information outside of the sample period and was excluded from the review. Of the 29 files reviewed, 19 were from WC and 10 from CHWC. Due to a limited sample of members refusing care, two additional files with linkages to community resources were included in the sample.
- The file sample content varied between WC and CHWC, and by member category. For example, the CYSHCN files contained all therapy and medication management notes, and often included significant amounts of information outside of the review period. These files were included as the care continued into the review period. Other files contained a combination of demographics pages, diagnostic pages, medical note, BH intakes, nurses note and care plans, making it difficult to obtain a clear clinical picture and timeline of services.

Behavioral Health/Physical Health Findings

- The CHWC BH team has access to the member's file but the physical health clinical providers have limited access, and can only see the plan of care and medications prescribed. Team members utilize telephone encounters as a workaround.

- The PE did provide evidence of universal BH screening, including screening for substance use disorders and there was often a referral to BH providers or the member was already in BH treatment.
- CHWC's plan of care has some aspects of a recovery tool but would need to be expanded to be considered a Wellness Recovery Action Plan.
- There was evidence in the WC files of Wellness Recovery Action Plans being used with their members. These Wellness Recovery Action Plans included identified goals and strategies and were revised every three months with the members. The Wellness Recovery Action Plans were able to be accessed by all team members.
- Files for members identified as Transition Age Youth generally did not address discussions related to transitioning from pediatric care to adult services. CHWC stated that they begin these member discussions at age 15 or 16. WC's process for Transition Age Youth is done on a case-by-case basis. There was some evidence in WC's EMR that transition discussions were happening but it was difficult to find any information in the file pertaining to a warm hand-off if the member was transitioned to an adult provider.

Children and Youth with Special Health Care Needs Findings

- One file from WC included an IEP and also demonstrated coordination between the medical specialists, the school and the care team. There were numerous family stressors identified and the file did include that support was given to the mother to engage in family therapy.
- Most CYSHCN files included care coordination notes, therapy notes, medication management and medical visit information.

Cultural Competency Findings

- The AN did provide evidence of assessing members for cultural needs and preferences but there was little evidence of incorporating culture into the plans of care. The members' cultural needs and preferences were listed in the history section of the record or assigned a global alert. The care coordinator would need to look through the telephone encounters or progress notes for the most up-to-date information.

Community Linkages Findings

- CHWC uses the PRAPARE tool to screen for SDoH while WC is using a similar tool embedded in their EMR. There was evidence in the files that members were assessed for housing, education, work, legal, social connections, refugee status and other stressors.

MEMBER INTERVIEWS

Member Interview Process

The input of members is key to the success of the PCMH+ program. Interviews with current PCMH+ members and/or designated family representatives focused on the member experience with PCMH+. In particular, interview questions solicited information about the member's experience with PCMH+ care coordination services and overall satisfaction regarding delivery of these services.

The PE selected the assigned PCMH+ member (and/or their representative) to voluntarily participate in an interview designed and 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 in the review period. 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.

Member Interview Findings

The PE arranged three interviews with PCMH+ assigned members. Two CHWC members participated in person and one member served by WC participated by telephone.

- All of the members were receiving PCMH+ enhanced care coordination interventions, which was confirmed by the PE.
- One member was a member of the patient advisory board and attended two meetings so far. The member believes his voice is heard and opinions are valued. The member gave an example of a discussion in the member advisory meeting regarding better methods of communicating with members and by the next meeting, plans were underway to address the problem. One member did not sit on the advisory board, but was interested in attending an upcoming meeting. The third member had not heard of the advisory board.
- None of the members had any issues accessing medical care. All three gave examples of being referred to specialists when needed. One member spoke about accessing three specialists and reported that staff assisted him with obtaining appointments and following up when appointments were missed. Another gave an example of needing an eye exam and receiving a referral with no problems. The third member described multiple past emergency department visits for pancreatitis, but now is seeing a specialist who is caring for her.
- All three members agreed that their providers show an interest in their care. The members felt comfortable voicing their opinions and/or disagreeing with their provider if needed. "It is not an intimidating environment." Two of the members have never had a reason to complain but feel confident on knowing how to file a complaint if an issue came up. One member stated he would go directly to the Primary Care Physician with any concern. The third member is currently filing a formal complaint and has discussed it with her Care Coordinator, who she feels comfortable talking with. Another member stated she felt her doctor is a good listener and is not judgmental.

- The members knew who their care coordinators were and were able to easily connect by phone or visit in person with them when needed. One stated her care coordinator is available at all times and sees the Care Coordinator regularly. “I don’t trust many people, but I trust her.”
- One member needed and received assistance with transportation. The other two members had not needed to utilize a community agency, although one expressed requiring help with a utility bill and was told to seek assistance from her Care Coordinator.
- A member described attending educational classes related to medical issues. Another member stated her Care Coordinator has helped her “feel normal.” “They’re in your corner.”

APPENDIX A

WHEELER TORRINGTON RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	The AN is continuing recruitment efforts to increase PCMH+ member participation on their advisory boards.	Formalize procedures to ensure substantial representation of PCMH+ member attendance at Member Advisory Board meetings and meet the requirement to hold meetings on a quarterly basis at a minimum.
	The AN has demonstrated a low penetration rate of 1.9% with approximately six care coordination contacts per month per care coordinator.	Evaluate PCMH+ enhanced care coordination member penetration rates and formalize procedures and documentation standards to track and increase the number of PCMH+ members engaged in care coordination activities.
	Starting in April 2019, the AN will begin submitting separate monthly reports for each FQHC. The separation of data will allow for improved analysis of implementation of the PCMH+ program at both FQHC.	Starting in April 2019, submit separate monthly reports for CHWC and WC.
	CHWC has separate PH and BH charts and members of the care team do not always have access to all member information. WC's EMR is fragmented without templates or a specific documentation protocol, which makes it difficult to easily review the member information.	Develop a plan to improve information-sharing across EMRs and standardized documentation procedures to improve coordination of care for all members.
Physical Health-Behavioral Health Integration	CHWC is developing processes to document if a member has a psychiatric advance directive and methods to include this in the member's file.	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.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	<p>CHWC is developing processes to engage with members about Wellness Recovery Action Plans or other recovery planning tools. The current plan of care has some aspects of recovery, but needs to be expanded to be considered a recovery-based tool.</p>	<p>Expand the existing care plan to include specific recovery components consistent with a Wellness Recovery Action Plan or other recovery-based tools.</p>
	<p>WC does not begin transition planning before age 18.</p>	<p>Formalize procedures to begin discussions with members about transitioning from pediatric to adult services. Recommend beginning the discussions by age 16 even if the member does not transition for several years or need to change providers.</p>
	<p>The AN is developing standardized documentation processes for transition-related discussions for Transition Age Youth.</p>	<p>Formalize procedures to develop standard documentation processes for discussions with Transition Aged Youth.</p>
<p>Children and Youth with Special Health Care Needs</p>	<p>The AN is developing processes regarding advance care planning with CYSHCN.</p>	<p>Formalize procedures to define, identify and develop advance directives for CYSHCN.</p>
	<p>The AN is developing processes to obtain IEPs and 504 Plans from the schools.</p>	<p>Strengthen processes to collect school information, including IEPs and 504 Plans where applicable for incorporation into the member's record</p>
<p>Competencies Caring for Individuals with Disabilities Requirements</p>	<p>The AN is developing standardized documentation standards regarding adjusted appointment times for members with disabilities.</p>	<p>Formalize procedures to document in the EMR members who received an adjusted appointment time.</p>
	<p>The AN has not yet implemented disability competency training.</p>	<p>Develop a training plan to train staff on the unique needs of members with disabilities.</p>
<p>Cultural Competency</p>	<p>The AN does not include cultural needs and preferences in plans of care.</p>	<p>Formalize procedures to incorporate member cultural needs and preferences in plans of care. A standardized template may assist with incorporation of these elements into the plan of care.</p>
<p>Community Linkages</p>	<p>The AN does not always clearly document care coordination efforts or demonstrate when an identified SDoH was resolved.</p>	<p>Formalize standardized documentation procedures for work pertaining addressing and resolving SDoH.</p>

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