HEALTH WEALTH CAREER

2017 PCMH+ PROGRAM

COMPLIANCE ASSESSMENT OF FAIR HAVEN COMMUNITY HEALTH CENTER

AUGUST 11, 2017

CONTENTS

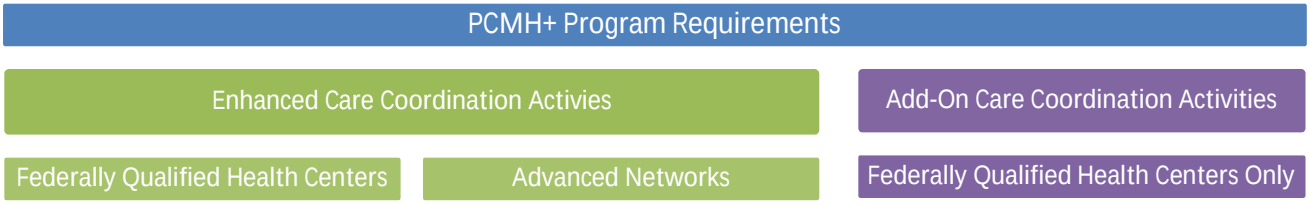
1
INTRODUCTION

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

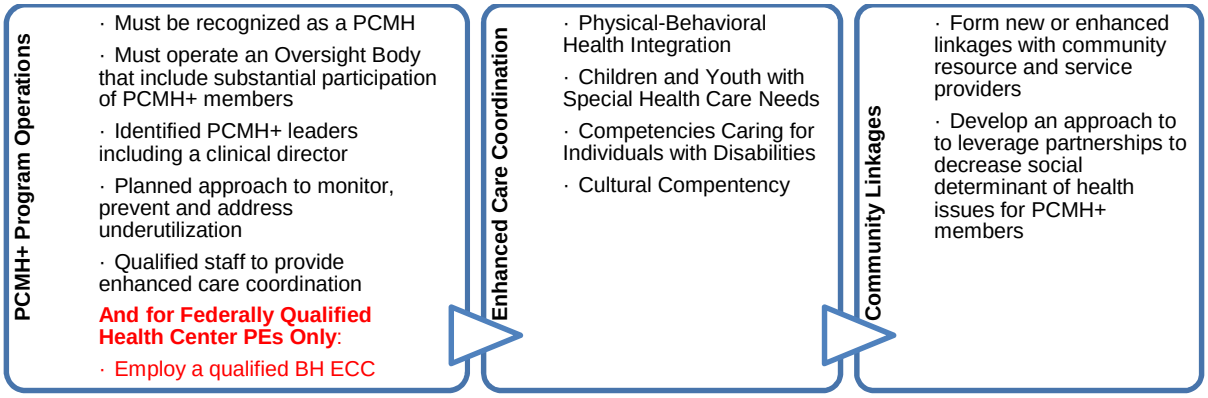
DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the DSS PCMH+ program and conduct reviews of PCMH+ program operations for all nine PCMH+ PEs. PCMH+ PEs are required to have current National Committee for Quality Assurance Patient-Centered Medical Home recognition as a prerequisite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

PCMH+ PROGRAM REQUIREMENTS

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

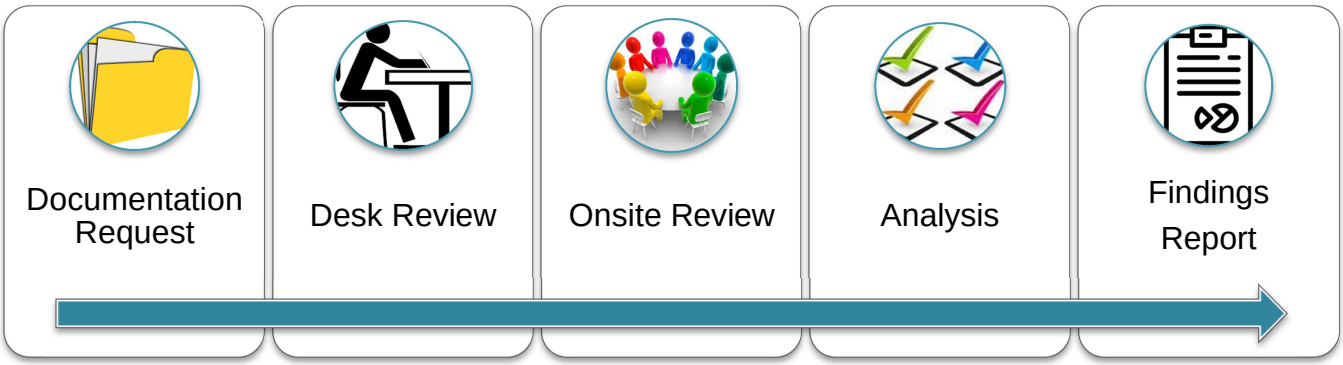


For PEs, like Fair Haven Community Health Center (FHCHC) that are a federally qualified health center, there are additional "Add-On Care Coordination" requirements that further drive behavioral health (BH) integration within the practice, including a qualified BH enhanced care coordinator (ECC) on staff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



REVIEW METHODOLOGY

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



DOCUMENT REQUEST — JUNE 2017

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

DESK REVIEW — JULY 2017

Mercer received information electronically and reviewed all documents submitted to evaluate the PE's compliance with PCMH+ program requirements as detailed within the PCMH+ Request for Information. Areas where Mercer could not determine that the process or procedure was fully compliant with PCMH+ program standards were noted for follow-up discussion during the onsite interviews.

ONSITE REVIEW — AUGUST 2017

The onsite review for FHCHC took place on August 11, 2017, at the offices located in New Haven, Connecticut. The onsite review began with an introductory session with the Mercer team, DSS staff, and appropriate FHCHC leadership. After the introductory session, the track teams split out into concurrent sessions and concentrated on the following areas focused specifically on PCMH+ program operations and PCMH+ assigned members; Program Operations, Enhanced Care Coordination, Member File Reviews, Member Interviews and Community Linkages. Onsite interviews included the following FHCHC staff:

- Suzanne Lagarde — CEO
- Doug Olson — VP of Clinical Affairs
- Abigail Paine — VP of Programs
- Evelyn Cumberbatch — Director of BH
- Evelyn Flamm — Director of Project Integration and Community Partnerships
- Vivian Acevedo-Rivas — Associate Director Care Coordination and Pt. Support Services
- Johanna Paris — RW Medical Care Coordinator
- Sofia Morales — Pediatric Care Coordinator
- Maribel Rosado — BH ECC

ANALYSIS AND FINDINGS REPORT — SEPTEMBER 2017

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

2
SUMMARY OF FINDINGS

FHCHC PCMH+ PROGRAM OVERVIEW

FHCHC is a federally qualified health center serving New Haven, Connecticut. FHCHC provides an array of primary care and specialist care to its members including: BH, Medication Assisted Therapy dental, infectious disease, midwifery and women's health, and pediatric and well child services. FHCHC offers extended weekday office hours (until 7 pm). Additional services offered by FHCHC include a mobile dental clinic, five school-based health centers, social services and a Women, Infants and Children program.

Under PCMH+, FHCHC provides enhanced care coordination activities to 7,383 PCMH+ members. Staffing for PCMH+ includes eight ECCs, who hold either a bachelor's or associate's degree. FHCHC utilizes one BH ECC, one Children and Youth with Special Health Care Needs ECC, one general ECC, one substance abuse ECC, two HIV ECCs, one prenatal ECC; and a manager of the ECC program who also provides care coordination to members. All of FHCHC's ECCs are bilingual and culturally diverse, which is reflective of their diverse, but largely Hispanic population. The Vice President (VP) of Clinical Affairs and VP of Programs provide executive oversight of the PCMH+ program and report to the Chief Financial Officer.

The ECCs are a part of an integrated care team model which works together in order to enhance the member's capacity to improve their health. FHCHC has reported that they have begun implementing Wellness Recovery Action Plans with their PCMH+ members. FHCHC reports the following monthly care coordination contacts: April 2017: 88 contacts; May 2017: 194 contacts; June 2017: 185 contacts; July 2017: 100 contacts.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	FHCHC has created a Patient Advisory Group to support the goals and policies of their PMCH+ program. There have been meetings held with four PCMH+ members attending in March 2017 and seven PCMH+ members attending in July 2017. Minutes from these meetings were distributed to the executive management team and member feedback was discussed at the weekly management team meeting.
	Functionality of Epic®, FHCHC's electronic health record, includes mechanisms that support the PCMH+ program including PCMH+ quality measure reporting (functionality that FHCHC developed since the inception of the program) tracking member gaps in care, by creating a flag for staff when members are due for a preventative health service and a flag to indicate members who are PCMH+.
	FHCHC's PCMH+ ECCs include staff experienced in the following areas: substance abuse, HIV, pediatric and perinatal.
	Most sites offer extended weekday hours (until 7 pm).

REVIEW AREA	STRENGTH
Physical Health-Behavioral Health Integration	As noted above, in addition to the BH ECC, FHCHC has a substance abuse experienced ECC supporting PCMH+ members.
	FHCHC has a process to consistently screen members for BH conditions using a variety of screening tools including: PHQ-2, PHQ-9, SBIRT (Screening, Brief Intervention, and Referral to Treatment is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs), CRAFFT (substance abuse screening tool for use with children under the age 21) and GAD (generalized anxiety disorder screen).
Children and Youth with Special Health Care Needs	The needs of Children and Youth with Special Health Care Needs are addressed through a comprehensive care coordination assessment tool. This was identified as a best practice.
Cultural Competency	FHCHC partners with Integrated Refugee and Immigrant Services to accompany the member/family on their first visit to address language barriers and cultural differences.
Member File Reviews	FHCHC identifies a member as a PCMH+ member in the electronic health record and collects a comprehensive set of cultural preferences, social determinants of health and needs which are documented in the member record.
	ECCs are proactive with members and demonstrate strong follow-through.
	FHCHC collects a comprehensive list of home health and durable medical equipment needs and documents this in the member record.
	FHCHC actively addresses the needs of Children and Youth with Special Health Care Needs through a comprehensive care coordination assessment tool which they plan to utilize for all members in the future.

OPPORTUNITIES

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

REVIEW AREA	OPPORTUNITY
Program Operations	Enhanced care coordination member penetration rates are low for the 7,383 assigned PCMH+ membership. FHCHC's reports the following care coordination contacts: April 2017: 88 contacts; May 2017: 194 contacts; June 2017: 185 contacts; July 2017: 100 contacts.
Underservice	While there was no evidence of underservice noted during the review, DSS recommends that all PCMH+ PEs develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.
Physical Health-Behavioral Health Integration	FHCHC is currently developing their Wellness Recovery Action Plan process and how they will identify members who would benefit from a Wellness Recovery Action Plan. They are developing their own recovery action plan using nationally available evidenced based tools as a guide.
Member File Reviews	FHCHC is still implementing the process to verify the presence of a psychiatric advice directive.
	FHCHC is still developing Wellness Recovery Action Plan processes and identifying those members who would benefit from a Wellness Recovery Action Plan.

3
DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

A. PCMH+ Program Operations Requirements

As the PCMH+ program builds upon PCMH practice requirements, all PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assistance or Primary Care Medical Home certification from The Joint Commission. Additional operational requirements include:

- Having an oversight body, supporting PCMH+ which includes substantial representation by PCMH+ Members.
- Having a senior leader and a clinical director providing oversight for the PCMH+ program.
- Having sufficient care coordination staff to provide the enhanced care coordination required activities to provide timely care coordination to PCMH+ assigned members.
- Having a quality program, including annual goals and annual quality work plan that includes specific PCMH+ program goals and activities.
- Evaluating and utilizing the results of provider profile reports to improve the quality of care.
- Completing and submitting the PCMH+ monthly report based on specifications provided by DSS.

B. PCMH+ Program Operations Findings

- Provider profile reports and Care Analyzer information provided by the HUSKY Administrative Services Organization, CHNCT, are used to check for accuracy against reports that FHCHC has created in their electronic health record (Epic®) for gaps in care reporting. FHCHC runs a report through their electronic health record to assess health risks of their population and identify cohorts of members who are in need of targeted, enhanced care coordination services and compares their findings to the profile reports and Care Analyzer information. Once the reports have been compared for accuracy, the information from the Epic® reports are given to the care coordination team so staff can promptly follow up to close gaps in care.
- FHCHC's electronic health record, Epic®, functionality includes mechanisms that support the PCMH+ program including PCMH+ quality measure reporting (functionality that FHCHC developed since the inception of the program) tracking member gaps in care, where Epic© creates a flag for staff when members are due for a preventative health service and a flag for members who are PCMH+ such that staff are aware of members who are participating in PCMH+ and reporting specific to PCMH+ can be conducted.
- FHCHC's PCMH+ ECCs include staff experienced in the following areas: substance abuse, HIV, pediatric and perinatal.
- FHCHC has created a Patient Advisory Group to support the goals and policies of their PMCH+ program. To solicit member participation, FHCHC hung flyers (both in English and Spanish) in waiting rooms, emailed all providers, and had an ECC reach out to members.

FHCHC offered food and transportation passes to members to ensure participation in the group. There have been two Patient Advisory Group meetings held with four PCMH+ members attending in March 2017 and seven PCMH+ members attending in July 2017. Minutes from these meetings were distributed to the executive management team and member feedback was discussed at the weekly management team meeting.

- FHCHC conducts a member survey that includes all members, including PCMH+ members.
- FHCHC has a quality program which includes annual goals, committee structure, quality improvement policies and procedures, a calendar of quality improvement activities, a quality improvement work plan and dashboard, and an inventory of data collection and monitoring.
- FHCHC conducted agency wide training for staff on elements of PCMH+ to increase familiarity with the program and to share program objectives.
- Enhanced care coordination member penetration rates are low for the 7,383 assigned PCMH+ membership, and appeared to be tracking upward until July 2017. The PE reports the following monthly care coordination contacts: April 2017: 88 contacts; May 2017: 194 contacts; June 2017: 185 contacts; July 2017: 100 contacts.

UNDERSERVICE

A. Underservice Requirements

In order to ensure that savings within the PCMH+ program are not derived by practices that limit a member's access to medically necessary services, or that complex members with higher cost needs are not shifted out of a PE's practice. Requirements include:

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

B. Underservice Findings

- There was no evidence of underservice noted during the review.
- FHCHC has a process to evaluate members who have requested a provider change. These requests are evaluated by the department chair and the reason for the request is identified and evaluated. The VP of Clinical Affairs is consulted on these decisions. FHCHC tracks volumes of these types of requests and will be tracking for increases since inception of PCMH+. Currently, they report no noted increase.

ENHANCED CARE COORDINATION

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

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

- Using standardized tools to expand 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; and
- Obtaining and maintaining a copy of a member's Wellness Recovery Action Plan in the member's file.

- Expanding development and implementation of the care plan for transition age youth with BH challenges.
- For federally qualified health centers only: Develop Wellness Recovery Action Plans in collaboration with the member and family.

B. PH-BH Integration Findings

- FHCHC has a process to consistently screen members for BH conditions. File reviews demonstrated consistent use of the PHQ-2, PHQ-9, SBIRT, CRAFFT and GAD.
- As previously noted, in addition to the BH ECC, FHCHC has a substance abuse experienced ECC supporting PCMH+ members.
- FHCHC is currently developing their Wellness Recovery Action Plan process and how they will identify members who would benefit from a Wellness Recovery Action Plan. They are developing their own recovery action plan using nationally available evidenced based tools as a guide. They report identifying around 150 members who could benefit from Wellness Recovery Action Plan planning and anticipate developing the plans one on one with members. FHCHC is considering if group sessions will be appropriate for their population. As FHCHC continues to develop their Wellness Recovery Action Plan processes, the review team encouraged them to consider expanding their identification procedures to include members with non-seriously and persistently mentally ill diagnoses but who also have complex psychosocial or social determinants of health factors that are disruptive to their lives and BH treatment.
- FHCHC identify transition age youth starting at age 14 and include transition planning in clinician notes. This is a narrative section of the note and not reportable at this time. They are working on reporting solutions with clinical staff and hope to incorporate a solution within Epic© in the future to allow tracking and reporting of transition age youth.
- Currently, FHCHC does not offer shared medical-BH appointments; however, this is an area they have self-identified as an opportunity and will be working to develop this capacity in the future.

A. Children and Youth with Special Health Care Needs Requirements

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

- Holding advance care planning discussions for Children and Youth with Special Health Care Needs.
- Developing advance directives for Children and Youth with Special Health Care Needs.
- Including school-related information in the member's health assessment and health record, such as: the IEP or 504 plan, special accommodations, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment.

B. Children and Youth with Special Health Care Needs Findings

- The needs of Children and Youth with Special Health Care Needs are addressed through a comprehensive care coordination assessment tool. This was identified as a best practice. The tool addresses needs in the school environment, requests contact information for the school and shows attempts to obtain the IEP/504 plan. The plan also addresses social determinants of health, BH, durable medical equipment and home health supplies, other medical or care coordination services and provides a follow-up plan for future care and appointments.
- The electronic health record used by FHCHC functions in some ways as a shared plan of care. All of the federally qualified health center's staff and even the large majority of treating provider partners (hospitals) are on the same platform. Sharing member information is facilitated and all treating providers on the system have access to the plan of care; however, FHCHC reports that there is not always one consistent "problem list" used across all disciplines.

A. Competencies Caring for Individuals with Disabilities Requirements

PCMH+ requirements for individuals with disabilities pertain to members with physical, intellectual, developmental and BH needs, and includes:

- Expanding the health assessment to evaluate members with disabilities for needed special accommodations in order to remain at home or access medical care or community resources.
- Adjusting appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs.
- Developing and requiring mandatory staff disability competency trainings to address the care of individuals with physical and intellectual disabilities.
- Acquiring accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam tables) and communication adaptive equipment.

B. Competencies Caring for Individuals with Disabilities Findings

- FHCHC cannot offer extended visits in Epic© to members who need them; however, staff members developed mechanisms to identify such members in order to offer extended visits when needed.

- FHCHC has the ability to provide additional support and accommodations for members including: accommodating service animals, providing visual support aids and interpretation services, including assisted senior living, adjustable exam tables, and wheelchairs for member use.
- Members are assessed for durable medical equipment and other home modification needs which were clearly documented in the member record. Elements assessed include: home care services, equipment used at home, communication devices or bed or wheelchair confined.
- FHCHC assesses for family awareness of member's advance care directive wishes, chronic pain and limitation of routine activities due to pain and exercise routines. This was also noted in the files reviewed.

A. Cultural Competency Requirements

Incorporating a member's cultural preferences and acknowledging that culture can expand beyond language and ethnicity is a key tenet of the PCMH+ program. Cultural sensitivity can help inform care coordination and other service interventions to better assist the member, particularly with regard to social determinant of health and community resource needs. The following are PCMH+ program Cultural Competency requirements:

- Conducting annual cultural competency training that includes methods to address the needs of members with disabilities for all practice staff.
- Expanding the individual care plan to include an assessment of the impact culture has on health outcomes.
- Integrating culturally and linguistically appropriate services standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

B. Cultural Competency Findings

- FHCHC contracts with an entity to provide online cultural competency training for all of its employees. FHCHC holds staff training, which includes cultural competency and disability competency, at the time of hire and annually.
- Race and ethnicity are documented in the member's electronic health record and to accommodate cultural differences, members are screened for health literacy. FHCHC partners with Integrated Refugee and Immigrant Services to accompany the member/family on their first visit to address language barriers and cultural differences and to make sure these are documented in the Plan of Care.
- FHCHC offers a translator from a partner agency, who has cross-cultural communication training, to their many refugee families.

COMMUNITY LINKAGES

A. Community Linkages Requirements

In an effort to meaningfully impact the PCMH+ members' social determinants of health, PEs are required to develop contractual or informal partnerships with local community partners, including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, and elder support services, and to further develop processes to link members to resources and community supports.

B. Community Linkages Findings

- FHCHC has developed a list of community resources that includes partnerships with organizations that provide services assisting members with employment, mental health and addiction, legal issues, child-serving and senior matters.
- Other relationships include providers of legal immigration services, as well as programs to help members who are formerly incarcerated, transgendered, or living with HIV.

MEMBER FILE REVIEWS

A. Member File Review Process

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

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

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

We asked that files include:

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

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

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

B. Member File Review Findings

- FHCHC clearly identifies a member as a PCMH+ member on the demographic screen (under member type).
- There was evidence of assessing social determinants of health, referrals to the needed community linkages and active follow up to ensure these linkages are complete and address the members' needs. Elements include: living arrangements, supports systems, family conflict, type of residence, financial problems, transportation issues and means, nutrition adequacy, medication adherence problems, history of falls, difficulty keeping appointments. FHCHC also assesses and scores for health literacy.
- Cultural preferences were documented. Elements include preferred language, as well as religious or spiritual beliefs that impact treatment.
- Home health and durable medical equipment needs are documented. Elements include home care services, equipment used at home, communication devices or bed or wheelchair confined. FHCHC also assesses for family awareness of member's advance care directive wishes, chronic pain and limitation of routine activities due to pain and exercise routines.
- Identified as a best practice, FHCHC assess the needs of Children and Youth with Special Health Care Needs through a comprehensive care coordination assessment tool. The tool addresses needs in the school environment, requests contact information for the school and shows attempts to obtain the individualized IEP/504 plan, social determinants of health, BH, durable medical equipment and home health supplies, other medical or care coordination services and provides a follow-up plan for future care and appointments. The goal of FHCHC is to ultimately implement this tool with all members.
- There was some evidence that the presence of a psychiatric advance directive is being verified, but evidence was inconsistent.
- FHCHC is still developing Wellness Recovery Action Plan processes and identifying those members who would benefit from a Wellness Recovery Action Plan.
- There was evidence of consistent screening for BH conditions.

MEMBER INTERVIEWS

A. Member Interview Process

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

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

B. Member Interview Findings

- FHCHC arranged interviews with PCMH+ assigned members, but only one attended.
- The member was receiving PCMH+ enhanced care coordination interventions, which was confirmed by FHCHC. She described her ECC as "excellent". She said her ECC has been pushing her into continuing her mental health appointments.
- Overall, the member was pleased with her providers. She did not indicate having issues receiving medical care. She said she has "a specialist for everything".
- The member was able to easily connect with her ECC by phone when needed. She also meets her ECC in person.
- The member was familiar with the process to file a complaint. The member stated that if she had a complaint, she would complain to her HUSKY insurance or nurse. She said that if she did not agree with a decision made by her provider(s), she had no problem discussing this disagreement with her provider(s) and she believed her provider(s) would be open to hearing her concerns.
- In regard to programs that might require linkages to the community, the member did mention that she utilized a domestic violence shelter and her provider helped her access this service.
- The member stated that "Fair Haven saved my life. There are very nice people here."

APPENDIX A

FAIR HAVEN COMMUNITY HEALTH CENTER RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	Enhanced care coordination member penetration rates are low for the 7,383 assigned PCMH+ membership. FHCHC's reports the following care coordination contacts: April 2017: 88 contacts; May 2017: 194 contacts; June 2017: 185 contacts in June 2017; July 2017: 100 contacts.	Evaluate current PCMH+ enhanced care coordination member penetration rate and develop a process to increase the number of PCMH+ members engaged in care coordination activities.
Underservice	While there was no evidence of underservice noted during the review, DSS recommends that all PCMH+ PEs develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.	Develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested
Physical Health-Behavioral Health Integration	FHCHC is currently developing their Wellness Recovery Action Plan process and how they will identify members who will benefit from Wellness Recovery Action Plan planning. They are developing their own recovery action plan using nationally available evidenced based tools as a guide.	Finalize the Wellness Recovery Action Plan process and ensure that for members who would benefit, that a Wellness Recovery Action Plan or other recovery action plan is developed in collaboration with the member and family.
Member File Reviews	FHCHC is still implementing the process to verify the presence of a psychiatric advance directive.	Formalize procedures to ask members if they have a psychiatric advance directive and methods to document the presence of a psychiatric advance directive in the member file.
	FHCHC is still developing Wellness Recovery Action Plan processes and identifying those members who would benefit from a Wellness Recovery Action Plan.	Formalize procedures to identify members who would benefit from Wellness Recovery Action Plan and the process to develop Wellness Recovery Action Plans with those members.

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