What’s Happened Since Last Enrollment?

The 2015 enrollment period concluded November 17, 2014. During the enrollment period, 135 PCMHs were enrolled, of which 25 were new enrollees who joined the program for the first time. These 135 PCMHs have a total of 764 physicians participating in the program.

In the 2015 performance period for PCMH, all PCMHs are able to participate in shared savings with the addition of the default pool for practices that did not choose to partner with other practices to form their own pool, or did not meet the 5,000 beneficiary count for a standalone pool. This year, we have seven standalone pools, 68 PCMHs participating in voluntary pools, and 60 PCMHs participating in the default pool. A list of practices participating in the default pool titled “PCMH - PCP List” can be found at http://www.paymentinitiative.org/medical-Homes/Documents/PCMH-PCP%20Web%20listing%2012182014.pdf.

Any provider needing to update their PCMH enrollment application can find the Update/Change request form on the AHIN portal at https://secure.ahin-net.com/ahin/logon.jsp. This form can be used to add or remove physicians and update primary contacts for the PCMH.

If you have any questions regarding the 2015 enrollment or how to make changes to your enrollment, please contact HP at 501-301-3811/ARKPII@HP.com.
Get the Benefits of SHARE
Even if Your Hospital Isn’t Connected

Today, 17 hospitals are using a live push application to securely send data to the State Health Alliance for Records Exchange (SHARE), which now totals 1.2 million discreet patient records. Another 8 hospitals are in the process of connecting to SHARE, including ACH and UAMS. If your hospital is not yet connected, reach out to them and ask them to connect. By using SHARE, your clinic can:

**Save time.** Reduce patient intake time, reduce duplicate tests and paperwork, and have more one-on-one time with patients.

**Save money.** One connection to SHARE gives direct access to many health care data partners, such as public health registries, and saves the enormous cost of having to pay an EHR vendor for each interface.

**Automate reporting to multiple ADH Registries.** Instantly send reports to public health databases such as Immunization, Cancer, HIV/AIDS registries, and other databases like Electronic Lab Reporting and Syndromic Surveillance. One interface will connect all databases without costly per-registry EHR vendor fees.

**Achieve Meaningful Use.** Satisfy up to 7 Meaningful Use criteria, including Stage 2 Core Objectives 15 and 16 that require sending a care summary with each transition of care or referral, and submitting electronic data to immunization registries. As an eligible provider, you can also earn EHR incentive payments by using SHARE.

**Position your clinic for other national payment reform initiatives.** Securely exchanging electronic patient health data with unaffiliated providers enables your clinic to handle transitions of care required for national reform initiatives.

Contact SHARE today at info@sharearkansas.com or call 501-410-1999.

Arkansas Center for Health Improvement Initiative (ACHI) Presents a PCMH Case Study

Following an interview with Dr. Lonnie Robinson of Regional Family Medicine in Mountain Home, ACHI developed *Patient-Centered Medical Homes: Aligning Incentives and Rewarding Innovative Collaboration*. The case study is available at [http://www.achi.net/Docs/290/](http://www.achi.net/Docs/290/). ACHI is an independent health policy center.
Practice Transformation vs. Care Coordination

The two efforts of Practice Transformation and Care Coordination are synergistic, not duplicative. Practice Transformation helps practices develop the systems and workflows to better manage their population, while Care Coordination touches patients who are complex and high risk. The maximum benefit occurs when both efforts are utilized.

The main features of Practice Transformation and Care Coordination are listed below for comparison.

<table>
<thead>
<tr>
<th><strong>Practice Transformation</strong></th>
<th><strong>Care Coordination</strong></th>
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<tbody>
<tr>
<td>Improves quality, safety, and efficiency by maximizing workflows and measuring performance</td>
<td>Assists clinical staff in developing care plans and updating care plans in the EMR</td>
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<tr>
<td>Coaches providers in strategies to increase care for patients (example: 24/7 care)</td>
<td>Assists clinical staff in identifying HPB</td>
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<tr>
<td>Enhances access by providing same-day appointments</td>
<td>Assists practices in identifying and outreaching to their complex patients</td>
</tr>
<tr>
<td>Employs team-based care to improve patient outcomes</td>
<td>Provides outreach to patients to schedule preventative care visits at least twice a year</td>
</tr>
<tr>
<td>Makes it possible for providers to engage in the Health IT systems for performance improvement</td>
<td>Performs medication management and home visits</td>
</tr>
<tr>
<td>Explores strategies to reduce healthcare costs</td>
<td>Coaches patients on self-management of chronic conditions</td>
</tr>
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Team-based care is a critical dimension of Practice Transformation and the medical home model. A well-organized and optimized care team can increase patient satisfaction, enhance efficiencies, provide continuity for patients, and close gaps in care.

**Practice Transformation Vendors:**
Arkansas Foundation for Medical Care (AFMC)
Qualis Health

With Care Coordination, direct patient outreach and education are key components to reducing unnecessary emergency room visits and preventable inpatient hospital admissions. Patient education is ongoing as care coordinators work with complex patients on a continuous basis.

**Care Coordination Vendor:**
Arkansas Community Cares
Through their Learning Collaborative Sessions and monthly informational webinars, the ARAAP is currently promoting PCMH by sharing information on: enrollment and re-enrollment, new pooling efforts, using data to decrease costs, understanding the medical neighborhood, creating effective care plans, and many other topics.

ARAAP upcoming events include monthly PCMH Informational Webinars hosted every fourth Tuesday at 12:15pm on 3/24/15, 5/26/15, 6/23/15, and an in-person Learning Collaborative meeting on 4/7/15. If you would like to attend and/or need more information on these events, please contact Kristen at kristen_pfeifer@yahoo.com.
What’s New in Quality Assurance

In December 2014, the AFMC PCMH Quality Assurance (QA) team completed onsite validation visits for the six month practice support activities. The PCMH QA team is excited to report that 101 (96%) of the 105 PCMHs that were eligible for validation successfully completed the six month activities. The QA team has received positive feedback from many practices related to the first round of onsite validation visits, and to the PCMH program as a whole. Further, all of the 101 PCMHs that successfully completed the six month activity validation have re-enrolled for the 2015 program year. This means that 74% of the 2015 PCMH Program enrollees are returning for another year in the program. AFMC offers its congratulations to those who completed the validation activities and re-enrolled for 2015!

Since January 2015, the QA team has been involved in validating the care plan metric tracked for practice support. The metric reflects the percentage of high-priority beneficiaries in 2014 whose care plan, as contained in the medical record, includes the four required components and is updated at least twice per year. The benefit of submitting care plans for 2014 is to prepare practices for the 2015 requirement of passing the metric to continue receiving practice support and care coordination payments.

As a reminder, practices placed in remediation for 2014 care plans will need to maintain their high-priority beneficiary list for 2014 until the end of the remediation period. This means these practices will have two high-priority beneficiary lists to maintain; the 2014 list and the newly selected list for 2015. To help providers gain a better understanding of requirements for meeting the care plan metric, the PCMH QA team will host a webinar at noon on April 22, 2015 to discuss results and findings from the current care plan validation activity. CME credits will be awarded for webinar participation. Additional information regarding the webinar will be distributed to providers as it becomes available.

-Shelely G. Fedor, Manager
PCMH Quality Assurance
Arkansas Foundation for Medical Care

Success Story: Empanelment Improves Report Accuracy

In October 2014, Sheryl Wilchman, office manager for Main Street Medical Clinic in Little Rock, came to appreciate empanelment. When her Qualis Health practice transformation coach visited the clinic, they discussed the importance of knowing which patients were still receiving the clinic's care and how empanelment ensures more accurate reporting.

One strategy they identified was doing outreach to patients who have not been seen within a given timeframe and asking if they still consider themselves patients of the clinic. Patients who responded in the negative would be made inactive. Based on this strategy, Sheryl ran reports on patients not seen in three years.

In the end, the front office staff made more than 2000 patients inactive in their EHR, which has been in use since 2008. Sheryl commented, “Cleaning up your panels will help with everything, apparently.” She now feels confident that their reports are more meaningful.

The clinic also plans on utilizing reports run out of eMDs in addition to the data provided on their PCMH Quarterly Reports.
In 2014, we focused on transforming how we manage our high-risk asthma patients at Conway Children's Clinic. We began by developing a simple tracking system using our EHR and a custom spreadsheet. We tracked each patient who was due for wellness checks, asthma evaluation and follow ups, pulmonary function tests, and flu vaccines. We used a system of phone calls and postcards to proactively contact patients before they were due for appointments. As a result, we saw our patients better control their symptoms and witnessed a decrease in ER visits for exacerbations.

We then used this system to track other high-risk patients with ADHD, obesity, and developmental delays. Each day, members of our established care teams identified high-risk patients on their provider’s schedule and checked for any needed preventative care, such as well-child checks, follow up appointments, and vaccines. This information was communicated to the nurse and provider of that care team. The results: We ended 2014 with 66% of our high priority patients with an up-to-date well-child check and 76% of our high priority patients up-to-date with their disease follow up.

Establishing care teams has been a big step toward increasing patient/provider continuity. We are now encouraging our patients to choose a provider to follow for all preventative care. Our goal is to have each patient identify with a specific provider and care team.

Our major goal for 2015 is to promote our patient portal. At every opportunity, we encourage our patients to sign up. We use the portal to send patients their care plans, education about their disease, Vanderbilt forms, and community resources. We ask our patients to use the portal to communicate medication refill requests, appointment requests, and questions for their care team. This has been a slow process, but patient feedback has been positive.

Overall, our practice transformation has focused on offering our patients more personal and individualized care. We want our changes to result in healthier patients who are better educated in managing their disease.

-Nikki Felkins, RN
Conway Children's Clinic
Conway, Arkansas

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**Adult Quality Grant Helps with 2015 Data Extraction Requirement**

With the support of the CMS Adult Quality Grant, Arkansas Medicaid is working to expand the existing portfolio of quality measurement and improvement activities that are foundational elements of our new initiatives for medical and health homes. We are collaborating with our Quality Improvement Organization, Arkansas Foundation for Medical Care, to coach PCMH practices throughout the state to extract hypertension and diabetes data from their own electronic medical records. This initiative is in alignment with the 2015 data extraction requirement for PCMH practices and we expect that it will assist practices in meeting targets while strengthening Arkansas Medicaid’s effort at payment reform and value purchasing.

-Cayla M. Henry, MHSA
Quality Improvement Coordinator
Division of Medical Services
Arkansas Department of Human Services

**Featured Provider: Conway Children’s Clinic**

**Practice Transformation Puts Focus on Patients**

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We encourage our providers to submit feedback via email. We’d like to know what you think of our newsletter. If you have any topics you would like us to explore or questions you want answered, please send us your suggestions.

We want your articles! Contribute to the PCMH program like Nikki Felkins in our featured provider submission.

Please email your ideas to us at pcmh@afmc.org.