Health Literacy

- **Are parents answering the Literacy Screening for all patients under age 18?**
  
  The addendum verbiage is provided below:
  
  Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers.

  A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMH's AFMC Outreach specialist.

  - Provide an example of the tool used to assess health literacy
  - Provide a description of the overall results of the assessment
  - Develop and describe a plan to help low health-literacy beneficiaries understand instructions and education materials

  Practices are to document completion of this activity via the provider portal, and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

- **What is the age range to meet the criteria for the Health Literacy activity and what percentage of patients are required to meet the activity?**
  
  The activity does not specify an age range or percentage. Activity J says to administer the screening to at least 50 beneficiaries.

  **Activity J:** Patient Literacy Assessment Tool: Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers.

- **Do the 50 beneficiaries “enrolled in the PCMH program” have to have Medicaid as a payer?**
  
  This activity applies to all payers, not just Medicaid.

- **How is this reported?**
  
  Practices are to document completion of this activity via the provider portal (AHIN), and attest that the described activity is complete and that proper evidence of such can be provided upon request.

Care Plans

- **One example of a care plan displayed in the webinar included acute problems. Are providers expected to address acute problems or chronic problems in a care plan?**
  
  If the problem is listed in the problem list, it has to be addressed. The problem list should include an active, significant and clinical condition. This is per the PCMH Program Policy Addendum, page 21. For the care plan, it is at the discretion of the practice whether it is an acute or chronic condition. A care plan will not fail based on acute problems being included on the problem list. What will cause the care plan to fail is if any problem listed on the care plan is not addressed.
• **Can we use PRN as a follow-up instruction on a care plan?**
  PRN is not sufficient as follow-up instructions. The follow-up should include the timing of a future follow-up visit (related to the problem(s)). This is per the PCMH Program Policy Addendum, page 21.

• **A previous care plan webinar was mentioned during the presentation. Where can it be found?**
  www.paymentinitiative.org Choose Patient Centered Medical Homes at the top, and then choose Key Webinars on your left. The PCMH Care Plan Webinar February 2017 is listed under “Quality Assurance.”

• **What documentation will you request for verification/audit of care plans?**
  The initial care plan and the update.

• **If we did not get to select our HPB until March and the beneficiary had visits in January/February and only needs one more visit in the year, am I correct that the MD cannot utilize the January/February visits for the first care plan?**
  The performance period is from January 2017 to December 2017. So applicable visits during the performance period will be captured. If the beneficiaries seen in January and February were chosen as a HPB, an initiated care plan at those visits is sufficient.

• **Are Registered/Certified Medical Assistants and LPNs allowed to prepare a care plan?**
  Yes. An MA and LPN may gather information on the patient for the care plan (for example, compiling the problem list, documenting blood pressure, A1c, etc.), but any decisions about the patient’s plan of care should be made by the physician.

• **Can the update be performed by an LPN/Care Manager?**
  An LPN or MA may conduct the follow-up/update to the care plan by gathering information (either in person or by phone), but they may not make decisions regarding the patient’s plan of care/treatment. The physician should review and sign off on the care plan.

• **In regards to phone call follow-up for care plans, can the LPN call a patient and document as long as the physician follows behind with ”I have reviewed and agree with the care plan update” and signs the note?**
  Yes, this is a very good process.

• **The care plan template does not have to be printed from our EMR. Can we put the information on the template based on chart notes? Also, I see the Care Team on your examples but you did not mention it when you talked about the requirements. Is that necessary?**
  You may enter the information from your EMR on the template. The template does not have to come directly from your EMR. The care plan team was not addressed because it is not a requirement. The example template was from a practice that already had that section on it. The practice actually had the physician’s name in that section, but for HIPAA requirements was de-identified.
• If the care plan is rather large, is it okay if we highlight the two visits to help the auditor find the information they are looking for?
  Yes

• Our APRNs have their own panel of patients within our practice. All visits are reviewed and co-signed by an MD. This has sufficed in the past; will it be acceptable this year as well?
  Yes. This is a good process and it will suffice for this year.

• Our past medical history auto-populates in our notes. If they had a diagnosis of alcohol abuse or even abdominal pain in the past medical history section, does it have to be addressed within the assessment on the visit note?
  If it is listed in the problem list, it has to be addressed. If the past medical history section carries over to the problem list in the care plan documentation that is submitted to QA for validation review, then it has to be addressed. Any problem that is listed on the care plan documentation must be addressed within the assessment.

• I understand that both an APRN and RN can initiate the care plan, but can LPNs follow-up with patients using the provider’s Standard of Care and making no decisions of their own?
  Yes, this is correct. A care plan may be initiated by the physician, APN or RN. An LPN or MA may complete the follow-up and gather information (either in person or by phone), using the provider’s Standard of Care, but they may not make decisions regarding the patient’s plan of treatment.

• If an RN completes the care plan update via telephone, does the physician have to co-sign the update?
  If an RN completes the update (either by phone or in person), it is good practice for the physician to co-sign (or sign off on) the update.

CPC+

• Where is the benchmark data for CPC+ that was mentioned by Dr. Golden?
  This information will be posted on the Payment Initiative website www.paymentinitiative.org

• BCBS has their own metrics for the CPC+ program. Does Medicaid have separate benchmarks for CPC+ or are they the same as Medicare as in years past?
  For the Medicaid population, we are following the current Medicaid PCMH program rules and requirements. For the Medicare population, you will follow the CPC+ requirements.
- **Do CPC+ practices that are not enrolled with Medicaid PCMH have to report on the Medicaid PCMH requirements for CPC+?**

  CPC+ and Arkansas Medicaid PCMH are two separate initiatives. If you are a CPC+ practice not enrolled in Arkansas Medicaid PCMH, you will follow the requirements for CPC+. If you are a CPC+ practice and enrolled in Arkansas Medicaid PCMH, you will follow the CPC+ requirements for the CPC+ initiative (Medicare) and you will follow the Arkansas Medicaid requirements for the Arkansas Medicaid PCMH initiative.

### Shared Savings

- **What is our window for requesting reconsideration to qualify for shared savings when we disagree with report results?**

  Practices have 30 days from the date of the notification letter to request a reconsideration. If you need assistance or have not received your Shared Savings notification letter, please email AFMC Provider Relations at pcmh@afmc.org.

- **I was told that I needed to wait for April reports, but I don’t have any 2017 reports on the AHIN portal for PCMH.**

  April reports are now available on AHIN.

- **What percentage of total PCMH practices are receiving shared savings for the 2015 performance period?**

  About 22 practices out of 135 practices are receiving shared savings.

### MISC.

- **Any ideas on how to meet the child/adult vaccination strategy when the clinic doesn’t do any vaccinations?**

  The detailed description of Activity F in the 2017 PCMH addendum states: Indicate and describe the practice’s implemented process to deliver immunization to both the pediatric and adult population leading into administration of immunization for the upcoming year.

  I would encourage you to look at the AHIN portal (under submit 12-month activities) to see what information is requested for attestation.

  If your practice doesn’t administer vaccinations, you need to be able to provide the process your clinic follows when beneficiaries need vaccinations upon request.

- **Will the history button on the AHIN portal help with cleaning up your Medicaid panel?**

  Yes! There is also a process to dismiss beneficiaries. If you need that information, please reach out to PCMH@afmc.org or your AFMC provider representative.

- **Where can we find the Medical Neighborhood report?**

  The Medical Neighborhood reports are located on AHIN under the Arkansas PCMH Portal for Medicaid. Once navigated to the home screen for PCMH, you will see a heading for Medical Neighborhood. If you need additional assistance, please reach out to PCMH@afmc.org.