Case Study
Patient-Centered Medical Homes: Aligning Incentives and Rewarding Innovative Collaboration

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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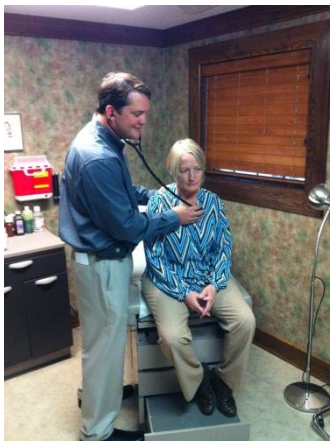
The Arkansas Health System Improvement Initiative is designed to create a sustainable patient-centered health system that embraces the triple aim of (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. While the initiative has broader goals of expanding coverage, enhancing health information technology, and developing a quality health care workforce, a major focus has been payment innovation and restructuring the system to incentivize quality outcomes. Patient-centered medical homes (PCMH) are a primary strategy of this innovation. Design and implementation of the state's PCMH efforts has been led by Arkansas Medicaid with support from Arkansas Blue Cross and Blue Shield, Qualchoice of Arkansas, Humana, Centene/Ambetter, Medicare, Walmart, the State Employees Plan, and others. This study is part of a series of case studies spotlighting practice transformation to the PCMH model, emphasizing how individual practices have approached innovation and implementation. For more information on the Arkansas Health System Improvement Initiative, and access to additional case studies, visit www.achi.net or www.paymentinitiative.org.

"The PCMH program is exciting for primary care providers who've typically been underpaid for the value they bring to the table – it's an opportunity to demonstrate their worth" --Dr. Lonnie Robinson of Regional Family Medicine in Mountain Home, AR



As a leader in the state's patient centered medical home (PCMH) program, Regional Family Medicine (RFM), nestled in Mountain Home, AR, in Baxter County, serves a panel of approximately twenty-six thousand patients. Including Dr. Robinson, RFM employs a staff of around fifty employees at their Main and East Branch Clinics, both in Mountain Home. The staff consists of eight doctors, three certified nurse practitioners (NP), several licensed practical nurses (LPNs) around ten administrative personnel, four X-ray technicians, two ultrasound technicians, and other staff.

RFM began participating in Arkansas's PCMH model in January 2014, and are now receiving per-member per-month financial support to enhance their patient-centered approach. RFM is also participating in the Ft. Smith Physician's Alliance, an Accountable Care Organization (ACO) within the Medicare Shared Savings Program (MSSP). Both programs incentivize providers to manage the overall quality and total cost of patient care. With the multi-payer PCMH model and other programs, RFM is now delivering a majority of care under a value-based purchasing model. Robinson said, "When the Medicaid PCMH opportunity arose, I thought we needed to participate, but I was concerned that it was a thin slice of our payer mix. Adding the private insurers to the model has been the critical part. Now with the PCMH program and the ACO, we have eighty to ninety percent of our care being delivered under some sort of value based model or alternative payment."

A major factor in the success of Arkansas's PCMH program to this point has been ongoing provider input. Many providers, including Dr. Robinson, who previously served as President of the Arkansas

Patient-Centered Medical Homes

Through improved care coordination and communication, the goal of the Arkansas patient-centered medical home (PCMH) program is to help patients stay healthy, increase the quality of care received, and reduce costs. A PCMH accomplishes this by identifying and treating at-risk persons before they become sick. Success of the Arkansas PCMH program relies on statewide multi-payer participation, ongoing innovation, and achievement of a specific set of improvement milestones, such as 24/7 patient access to care via phone or e-mail, use of electronic health records, and development of customized care plans for each patient.

BAXTER COUNTY PROFILE

Overall County Health Ranking: 20 (of 75)
Uninsured: 20% (AR: 20%)
Primary Care Physicians: 1,093:1 (AR: 1,586:1)
Diabetic Screening: 88% (AR: 82%)
Mammography Screening: 69% (AR: 58%)
Social & Economic Factor Ranking: 21 (of 75)
Poor or Fair Health: 18% (AR: 19%)
Mental Health Providers: 507:1 (AR: 696:1)
Low Birth Weight: 7.3% (AR: 9.0%)
Unemployed: 7.7% (AR: 7.3%)
*http://www.countyhealthrankings.org/app/#!/arkansas/2014/rankings/van-buren/county/outcomes/overall/snapshot

Academy of Family Physicians, have worked with public and private payers on a strategic advisory group to shape the state's Arkansas-centric program. A key design element of the model is that providers have the opportunity to partner or "pool" with other participating practices. This feature enables more providers, many of whom are in smaller practices, to be potentially eligible for shared savings. The pooling feature also incentivizes PCMHs to share best practices and work together towards meeting quality targets and managing costs. Robinson said, "We are pooling with Baxter Regional Medical Center (BRMC) clinics and Lincoln-Paden Clinic. We have met with members of the Lincoln-Paden team to offer some advice about selecting an EHR and getting started on the path to PCMH transformation. I think that collaboration between provider groups is going to be important to our mutual success. For them to succeed is for us to succeed." Currently within the states PCMH program, 71 individual PCMHs have formed 25 voluntary pools, and 63 PCMHs are in a statewide pool.

"We formed a transformation team early in the process – and everyone wanted to be on the team. Empowering our staff through the PCMH model has been very helpful. In the past our model was very physician-centric… now we are all taking care of the patients as a team"
--Lonnie Robinson. MD

Like many PCMHs throughout the state, RFM has refined the roles of their staff to achieve better-coordinated, team-based care. Each physician at RFM works closely with two nurses, one of whom serves as the care coordinator. "When we began thinking about what team member might best serve as care coordinator, it became obvious to us that one of the nurses on each care team was already filling that role to a large degree. Thus, we're able to fill the role without hiring another employee", said Robinson. By facilitating optimal communication, including 24/7 live-voice access, RFM has influenced patients to seek care in an appropriate setting. Robinson said, "I tell my patients to call me if they have an issue, and we'll keep them out of the emergency room. I think patients like it, knowing there is someone they can talk to gives them comfort - access is what matters most to patients, being able to be seen in a timely manner." In addition to the benefits to patients, the staff at RFM has become more engaged in the team-oriented model and as a result is more satisfied with their jobs. Robinson said, "Engaging with staff about how we talk to patients and giving them a voice has been good. I'm a fan of the quadruple aim, provider satisfaction added, with the whole team operating at the top of their license."

"We've seen a 9% drop in inpatient admissions from RFM, and we're expecting that number to drop more"
--Ivan Holleman, CFO, Baxter

By aligning incentives and assigning responsibility for overall patient care to primary care providers (PCPs), The PCMH model has improved linkages and transitions of care between clinics and hospitals or other care settings. "We've seen a nine percent drop in inpatient admissions from RFM", said Ivan Holleman, VP and CFO of BRMC, one of the main hospitals serving Mountain Home and the surrounding areas. BRMC has joined the state's health information exchange, The State Health Alliance for Records Exchange (SHARE), to receive alerts for patient admissions, discharges, or transfers (ADTs) that will notify RFM and other groups and help reduce unnecessary readmissions. "We're working on sending real-time data back to primary care providers. SHARE will put us in a better position to work with PCMHs as we transition patients, from inpatient to outpatient settings," said Holleman. For many providers working to manage care and referrals efficiently, a challenge is gaining access to data, improved data transparency. "We have had discussions with BRMC about the expected impact of PCMH on their bottom line. PCPs have an inherent obligation to pursue the options for patients that provide the best quality and outcome at the lowest cost, now that this information is available to them. We will all have to adjust to this new environment, and we want to engage with our hospital and specialist providers to seek out ways we can all thrive while caring for patients in this new reality" Robinson said.

This report was composed using information obtained during an in-person interview with Dr. Robinson of Regional Family Medicine. The Arkansas Center for Health Improvement was granted written permission to use this information. Additional information was gathered from the Arkansas Department of Human Services Division of Medical Services, the Arkansas Center for Health Improvement, and County Health Rankings from the Population Health Institute at the University of Wisconsin.