Case Study
Patient-Centered Medical Homes: Focus on Pharmacy Innovation

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, its major focus has been payment innovation and restructuring the system to incentivize quality outcomes. Patient-centered medical homes (PCMHs) are a primary strategy of this innovation. Design and implementation of the state's PCMH efforts have been led by Arkansas Medicaid with support from Arkansas Blue Cross and Blue Shield, QualChoice of Arkansas, Humana, Centene/Ambetter, Medicare, Walmart, the State and Public School Employees Benefits Plans, 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.

Practice Profile

Split between two physical offices across the city, Little Rock Family Practice Clinic (LRFP) is a 12-physician practice serving patients of all ages. Founded in 1963, LRFP has a location in West Little Rock and a second site in the central part of the city. LRFP serves approximately 31,000 patients across the two sites, and each provider sees anywhere from 25-40 patients each day. The physicians are assisted by three care coordinators, a dietician, four health maintenance staff, and as of recently, a full-time in-house pharmacist. The practice is one of an original 69 practices around the state chosen to participate in the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care (CPC) initiative.

Led by Medicare in different regions around the country, the CPC initiative is a joint federal, state, and private payer effort to develop patient-centered medical homes (PCMHs). The CPC initiative requires meeting select milestones to ensure that care delivery is truly patient-centered. Participating clinics receive upfront per-member per-month payments to help transform their practices as well as to coordinate better and more comprehensive care for their patients.

PCMH Innovations

To coordinate CPC activities among the 12 providers, a team of three physicians serves as part of a committee helping to streamline practice-wide infrastructure decisions. These three physicians have designed triggers within the electronic medical record system for discharge notifications, increased patient education materials, and made the decision to hire a pharmacist.

Bringing on a full-time pharmacist has been both a benefit and a challenge. Because of the large patient load between the two locations, LRFP felt confident there was enough opportunity for a pharmacist's intervention in medication management and improving adherence. This would hopefully help patients achieve better health outcomes and avoid costly hospital stays. The challenge for LRFP is that they are unable to bill for these services through traditional means, and therefore need to build the position in across their entire business model.

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.

PULASKI COUNTY PROFILE

Overall County Health Ranking: 22 (of 75)
Uninsured: 17% (AR: 19%)
Primary Care Physicians: 924:1 (AR: 1,562:1)
Diabetic Screening: 82% (AR: 83%)
Mammography Screening: 63% (AR: 58%)
Social & Economic Factor Ranking: 24 (of 75)
Poor or Fair Health: 15% (AR: 19%)
Mental Health Providers: 291:1 (AR: 556:1)
Low Birth Weight: 10.5% (AR: 9.0%)
Unemployment: 6.9% (AR: 7.5%)
*http://www.countyhealthrankings.org/app/arkansas/2015/rankings/pulaski/county/outcomes/overall/snapshot

LRFP CPC Facilitator Marie Stacks said the practice conducted a national search for the right pharmacist to bring on board. They were looking to find someone with ambulatory care experience who would be willing to learn how to optimize the new model. Stacks said the hired pharmacist fit all requirements "to a T." While the pharmacist began at LRFP in August 2014, it took several months for the practice to figure out how to best schedule and manage the new position.

Pharmacy Integration into Private Practice

In order to maximize the pharmacist's potential impact in the clinic, she splits her time between the two locations on alternating days. The practice also brought on an Access Coordinator that can manage the pharmacist's schedule to make sure patients in most need of medication reconciliation have access to the pharmacist during regularly scheduled appointments. The pharmacist's appointments normally last about 60 minutes for new or high-risk patients with diabetes, about 30 minutes for standard medication management, and pre-scheduled regular appointments can last 15 to 60 minutes with the pharmacist.

The drive to pursue a pharmacist came from seeing high medication costs across their panel of patients as well as matching a defined pathway for meeting one of the CPC initiative's milestones—"planned care for chronic conditions and preventive care." In order to achieve this milestone, LRFP had to specifically target higher risk cohorts. Knowing that the chronic issues that are common across its panel (e.g., diabetes, chronic obstructive pulmonary disease, and congestive heart failure) often require medication intervention and adherence, they knew hiring an expert in drug effectiveness and interactions would benefit not just the high-risk patients but also all members of the practice.

While long-term results and a return on investment analysis will take a while to develop, LRFP now makes sure that their high-risk and multiple-medication patients are scheduled to see the pharmacist as part of their routine visits. The pharmacist also conducts joint visits with the practice's dietician for new and high-risk diabetics. Patients seen at the emergency department or discharged from the hospital are automatically contacted by care coordinators for a follow up which includes medication reconciliation with the pharmacist.

Clinic Progress and Pacing

The changes LRFP has made have shown some positive results. Both hospital admissions and emergency department visits for their patients have gone down by 12 percent since joining the CPC initiative in 2012. These findings show that improving care coordination and patient engagement can have real effects on both patient outcomes and costly care.

> *"As the {CPC} coordinator, I think my biggest assistance has been other practices…being able to talk to other people that have already implemented or that are thinking about it. Being able to bounce ideas around is very beneficial."*
>
> --Marie Stacks, CPC Facilitator, LRFP

When asked what they liked most about the PCMH model, LRFP shared they appreciated that the PCMH fostered a team environment and improved care coordination. Most of all, "the patients love it!" Stacks said that patients had noticed the increased communication when there was a need for follow up or medication reconciliation. They also appreciated LRFP having extended and weekend office hours and access to doctors via their medical exchange. Having these types of responses from patients encourages the practice to continue.

LRFP knows that more changes will be required in order to continuously improve the practice as time goes on. The practice has benefitted from the resources provided through the CPC program, specifically the practice transformation vendor, TransforMed, and the Learning Collaboratives held throughout the year. Still, there are challenges for any new practice coming on board, mainly due to the time demands on both practice managers and clinicians. LRFP is confident that, though time intensive, the changes they are making are in the best interest of their patients.

This report was composed using information obtained during an in-person interview and discussion with the CPC practice coordinator of Little Rock Family Practice Clinic. The Arkansas Center for Health Improvement received written permission to use this information. Additional information included 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.