Introducing ARCH

The most commonly travelled routes to health care reform—like interstate highways—largely bypass rural America. As such, health care reform strategies like accountable care may inadvertently threaten the fragile rural health infrastructure by rerouting financial, technological, and human resources to support metro-centric reform models. PrimeWest Health constructed Accountable Rural Community Health (ARCH) to bridge the gaps—conceptual, cultural, and political—that separate the goals and benefits of health care reform and accountable care from rural Minnesota.

PrimeWest Health is shifting its operational approach from traditional managed care to an approach of provider-payer shared accountability and value-based health care and human services delivery and financing for the Minnesota Health Care Programs (MHCP) we administer in our 13-county service area. The programs include: Medical Assistance, MinnesotaCare, Minnesota Senior Care Plus, Minnesota Senior Health Options, and Special Needs BasicCare.

PrimeWest Health believes ARCH provides a feasible and plausible opportunity to achieve “Triple Aim” in rural areas and to ensure public resources (Medicaid and Medicare dollars) are as beneficial to rural residents and rural health providers as possible. As the name “Accountable Rural Community Health” implies, ARCH is designed for rural areas to share accountability for achieving Triple Aim* among providers, patients, community stakeholders, and PrimeWest Health. ARCH aligns health care spending and incentives with outcomes, quality, and population health and wellness. ARCH utilizes patented information technology developed by PrimeWest Health, patient-centered Health Care Homes (HCH) and wellness management approaches, community reinvestment and development strategies, and alternative provider payment methods for:

1. Improving care outcomes and quality;
2. Improving population health; and

*Institute for Healthcare Improvement
Why PrimeWest Health?

As a county-based health care purchasing organization owned and governed by the 13 rural Minnesota counties it serves, PrimeWest Health is uniquely positioned to implement ARCH. The counties created PrimeWest Health 15 years ago as an alternative to the administration of Medicaid and Medicare in rural areas by private HMOs. They sought this alternative for many of the same reasons that the Federal government, the State of Minnesota, and health and human services providers are pursuing health care reform and accountable care today.

PrimeWest Health provides health coverage to county residents who qualify for Medicaid, Medicare, and other public health programs. We do this through contracts with and financing from the Minnesota Department of Human Services (DHS) and the Federal Centers for Medicare & Medicaid Services (CMS). Approximately 24,000 local residents (over 10 percent of the 13 counties’ total population) are enrolled in PrimeWest Health.

PrimeWest Health is organizationally integrated with its 13 owner counties, including local public health and social services agencies. The integration of publicly funded insurance coverage, public health, and social services at the local level was a primary reason for the creation of PrimeWest Health, and this organizational alignment now provides the foundation for implementing ARCH.
Building ARCH
Like any structure, ARCH was built out of specific needs and circumstances. Those needs and circumstances dictated not only the building blocks, but the processes used to build it as well. In the pages that follow, we will explain the foundation that ARCH was built upon and the elements and processes that form its key structural components: member participation and patient attribution, provider integration and care coordination, and realignment of financial incentives. We conclude with a brief discussion of the support needed to continue ARCH’s success and the evolution we anticipate for the future of ARCH.

Foundation
State Health Reform Priorities and ARCH
PrimeWest Health began developing ARCH in 2008 as a means to improve care outcomes and quality, improve population health, and reduce health care spending in a way that would account for the health care attributes and challenges unique to rural areas. The attributes include a culture of self-reliance, local problem solving, and collaboration, while the challenges include fewer health care providers and resources, fewer integrated health care systems, lower patient population density, and significant geographic distances separating local providers and patients from specialized providers and resources.

ARCH incorporates key elements of the health care reform plan spelled out in the State Innovation Model (SIM) application that Minnesota submitted to the Federal government. Minnesota’s SIM calls for the development of new Accountable Community Health (ACH) partners and sites in 2015 and 2016—a deadline ARCH has preceded by a full two years. Because ARCH builds upon the existing infrastructure and expertise of local providers, the strengths of rural communities (e.g., open lines of communication, ease of working together), and county risk-bearing organizations (like PrimeWest Health) for Medicaid and Medicare services, ARCH is “shovel ready.” Implementation began in January 2013 with no additional cost to the State.

ARCH Rural Paradigm Shift
Most health care reform approaches designed to achieve Triple Aim are based on conditions that exist largely in metropolitan areas. These approaches assume the presence of a large, stable, and diverse patient base that is served by multiple, large, vertically integrated health care systems. However, conditions in rural Minnesota, including the areas served by PrimeWest Health, are usually quite the opposite. Therefore, ARCH approaches accountable care, patient-centered health care homes, integrated service delivery, and value-based reimbursement on a scale that matches the realities of rural health care.
In addition, ARCH essentially flips the traditional local-to-regional, rural-to-urban flow of integration and control, a tradition that in the past has threatened rural health care and access to care for vulnerable rural residents. In the 1980s and ‘90s, HMOs and managed care spurred health care integration movements that were driven by large, metro-based tertiary providers and systems looking to optimize their specialist-based business models. Rural providers were integrated as patient referral or “feeder” sources for specialists and tertiary care facilities. As a result, rural providers had diminished control over referral choices and patterns. Consequently, rural health care systems began to decline, shrink, and, in some rural communities, vanish as the flow of patients and revenue was increasingly channeled to regional and metropolitan medical centers.

**Specialist-Centered Integration Model**

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<th>Rural Provider</th>
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<th>Metro-Based Specialist</th>
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<td>Rural Provider</td>
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The 1990's costly, failed response to integration demands

**ARCH Integration Model**

<table>
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<th>Local Primary Care Provider</th>
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ARCH is designed to help rural providers organize and manage health care integration

In ARCH, the primary care HCH is the hub of the system with referral and integration decision making solely in the hands of the HCH. This is accomplished by providing the HCH with the information, financial, and technical resources necessary to more independently and impartially base its patient referral and organizational alignment decisions based on the value proposition (quality and effectiveness of care/treatment versus cost) of competing specialists and specialized services and facilities. Through ARCH, rural providers exercise and enjoy greater control over health care resources by assuming greater accountability for care management, health care utilization, care/treatment outcomes, health improvement, and health care costs.
Rural Integration and ARCH

Achieving Triple Aim requires a high degree of alignment between health care providers and service delivery. However, many local health care “systems” in rural Minnesota lack such alignment. Unlike metropolitan areas with large, vertically integrated health care systems, rural communities are often served by a mix of independently owned and operated health care and human services providers. While some providers offer a limited degree of service integration (e.g., integrated primary care clinic and hospital), most are single service or sector-specific providers (e.g., primary care clinic, hospital, nursing home, pharmacy, medical supplies, emergency transportation, home health, etc.). Even in rural counties served by larger integrated systems, comparatively few secondary and tertiary services are locally available and integration mostly includes traditional inpatient and outpatient medical services providers. To address this challenge, ARCH contains a strong strategic alignment element.

PrimeWest Health utilizes a three-step approach—integration, coordination, and motivation—based on proven community development practices to align and incent independent health care and human services providers to achieve Triple Aim through ARCH.

Integration – The patient-centered HCH serves as the accountable hub of care management and coordination for wellness and health care services delivery. ARCH virtually aligns and integrates independent health care and human service providers including the HCH, medical specialists, hospitals, public health, social services, behavioral health (mental health and chemical dependency treatment), pharmacy, dental, home and community based services, and long-term care. This is accomplished through ARCH Interdisciplinary Care Teams, contracts, Memorandums of Understanding (MOUs), mutually developed workflows, and electronic information exchange networking.

Coordination – The HCH is the lead entity accountable for coordinating patient-centered and outcome-focused care and the total cost of care, including medical, behavioral health, public health, home and community based services, and appropriate social services. Patient-centered care coordination and evidence-based disease management models employed by the HCH and providers do the following:

• Address and manage complex, chronic, and high-risk conditions/behaviors that affect individual and population health
• Reduce the need for and utilization of services for treating health problems caused by unmanaged complex, chronic, and high-risk conditions/behaviors
• Improve the individual’s quality of life with less reliance on costly health care services and intervention

Motivation – ARCH aligns provider reimbursement and other financial incentives with Triple Aim objectives through capacity building grants, ongoing care management support funding, targeted quality performance incentives, and shared gain and/or risk for the total cost of care. This includes applying value-based reimbursement methodologies to financially motivate key providers to integrate and coordinate health care.
Member Participation and Patient Attribution

Effective total cost of care management requires patients to be attributed to accountable providers in a timely and accurate way. This is especially important when provider reimbursement includes per member per month (PMPM)-based care management payments, risk sharing, or shared savings arrangements. Therefore, PrimeWest Health uses a prospective (rather than retrospective) patient attribution approach for clearly identifying the target population and creating the patient population baseline essential to effectively managing patients’ health and health care costs. Through ARCH prospective patient attribution, providers know the names of all members for whom they are accountable at any given time.

The ARCH Attribution Approach

The ARCH patient attribution approach starts with the PrimeWest Health member selecting a primary care provider. All members enrolled in PrimeWest Health are eligible to participate in the ARCH model if their primary care provider is participating as an ARCH HCH. If the member does not select a primary care provider, PrimeWest Health assigns him/her to one based on the member’s health care utilization history. If such data are not available, PrimeWest Health assigns the member to a primary care provider closest to his/her home address. Thereafter, PrimeWest Health regularly reviews the member’s health care utilization patterns to ensure the primary care provider or HCH selected by or assigned to the member is consistent with the actual health care utilization patterns. If the assignment/selection is not consistent, PrimeWest Health reassigns the patient to the primary care provider most commonly utilized by the patient. This approach not only ensures accurate, real-time patient attribution, it also preserves member choice of primary care providers and HCHs.

The ARCH approach accounts for the dynamic enrollment characteristics of Medicare and Medicaid, including frequent enrollment and disenrollment.

Prospective Attribution

The primary advantages of prospective attribution include strengthening clinic incentives for the following:

**New member outreach** – The same life circumstances that lead to eligibility for public programs can also create outreach challenges. Addresses and phone numbers may not be current, and responding to health plan letters or messages may have a lower priority than more urgent day-to-day tasks. Local HCHs’ credibility can provide an outreach advantage for successfully establishing contact with new members. Under prospective attribution, clinics will have the information necessary for outreach.

**Enhancing HCH relationships** – Some members will have well established relationships with their primary care clinic or HCH while others will not. For most members, contact from an HCH such as an invitation for a checkup, screening, or other needed service is likely to be well received. Under prospective attribution, member assignments will be kept up-to-date based on the primary care clinics most frequently used, and ARCH HCHs will have the information they need to contact patients and enhance their relationships as true health care homes.
**Accountable Rural Community Health (ARCH) Member Assignment and Prospective Attribution**

1. **Member enrolled with PrimeWest Health**
   - PCC selected by member?
     - Y
     - N
       - Assign member to participating PCC/HCH geographically closest to his/her home address
       - Utilization indicates possible PCC/HCH reassignment
       - PrimeWest Health reviews member utilization patterns
     - N
       - Member assigned to a non-ARCH PCC/HCH
       - Member attributed to an ARCH PCC/HCH
   - N
     - Assign member to PCC/HCH based on utilization
     - Is the PCC/HCH an ARCH PCC/HCH?
       - Y
       - N

**Legend**
- **HCH** = Health Care Home
- **PCC** = Primary Care Clinic
Building ARCH Interdisciplinary Care Teams – An effective ARCH Interdisciplinary Care Team requires active participation of all providers. Prospective attribution facilitates this by allowing more timely and proactive engagement by primary care clinics because providers know with certainty which patients they are responsible for rather than waiting weeks or even months for confirmation through retrospective attribution. HCHs, public health, social services, long-term care and home and community based service providers, and other caregivers can form ARCH Interdisciplinary Care Teams timelier and with full knowledge of their attributed patient population.

Total cost of care initiatives – Prospective attribution gives accountable providers greater capacity to analyze, develop, and implement initiatives to improve total cost of care with the confidence that they are focusing on the right population. Prospective attribution also increases the total dollars at stake by bringing 100 percent of enrollees into the funding pool, rather than just the subset that qualifies for retrospective attribution. This includes the significant subset of members who have no claims for a given attribution period, but may benefit from a checkup and the development of a stronger HCH relationship. The prospective approach avoids shortfalls in expected savings and/or pay-for-performance measures. With retrospective attribution, shortfalls can occur when claims are submitted for members who have not been seen regularly in a clinic or whose attribution the clinics were unable to anticipate.

The one disadvantage of prospective attribution is the potential for a member to be assigned to a clinic that is not the clinic used most frequently by the member. To avoid this problem, PrimeWest Health regularly monitors members’ utilization of primary care providers to ensure they are actually using the HCH to which they are attributed.

Provider Integration and Care Coordination
Health care consumers are served by multiple providers, organizations, and systems that affect health status and quality of life (e.g., medical, public health, social services, mental health, chemical dependency treatment, environmental health, public safety, long-term care, etc.). However, such services, if not integrated and coordinated, tend to be fragmented and delivered in silos, resulting in duplication of services, poor role definitions among various providers, redundant costs, inefficient service delivery, and diminished individual and population health status.

Provider Integration
ARCH has developed a three-pronged approach to integrating health and human services providers:
• Organizational
• Virtual
• Locational
Organizational Integration – As a county-owned health care purchasing organization, PrimeWest Health is already organizationally integrated with county agencies and departments, including public health and social services. This integration is critical for care coordination because county public health and social services are typically the primary or only sources of case management for MHCP participants in rural areas. Also, through its provider contracts, PrimeWest Health connects private and public sector health care and human services providers into one seamless provider network. Therefore, through ARCH and PrimeWest Health’s integration with county public health and social services, the HCH is connected both to the care management network in rural counties and to nearly 8,000 PrimeWest Health network providers representing the entire spectrum of health and human services.

Virtual Integration – In the absence of a health care system in which components are integrated vertically and/or horizontally through common ownership, ARCH uses provider network participation agreements, patient care management agreements, provider incentives, cross-provider organization workflows, and electronic health information networking to virtually integrate the services and competencies of independent providers. In this way, independent providers can act as one in the care and treatment of their ARCH patients.

In addition to being the only practical way to link independent providers in rural areas, virtual integration can be a more flexible form of integration than its organizational counterparts. Thus, virtual integration may be more conducive to consumer-driven, person-centered health care delivery and coordination. For example, through virtual integration, an entire array of independent providers can be assembled, coordinated, and re-assembled around an individual’s changing health care needs as identified in his/her health assessment(s) and care or treatment plan. Of course, virtual integration cannot work without provider participation. Therefore, ARCH leverages providers’ shared clinical and business interests to motivate them to virtually integrate and jointly pursue Triple Aim. The levers include common missions, public image, market share, and financial incentives (i.e., value- and outcome-based reimbursement methodologies).

Locational Integration – ARCH includes two locational integration strategies. The first involves placing a county public health and/or social services case manager in the HCH and/or hospital. In smaller HCHs, this case manager may also serve as the care coordinator. By placing county case managers in the HCH and hospital, ARCH relies on physical proximity to facilitate optimum coordination between the member’s HCH care coordinator, primary care provider, hospital caregivers and discharge planners, and public health and social services. The second strategy involves placing mental health providers in HCHs. This locational integration approach facilitates timely coordination between medical and behavioral health providers. This is particularly critical for managing the care of individuals with physical and/or behavioral health (mental health and/or chemical dependency) comorbidities in a cost-effective manner.
Information Exchange: The Key to Successful Integration

Health information technology

Health information is the most critical element of any integrated health care network. Efforts to better integrate and coordinate care in the 1980s and ‘90s failed in part because health care providers and payers lacked interoperable electronic health information systems that could transmit information to one another in a meaningful and timely manner. This technology now exists. However, rural providers still largely lack a health information exchange that is adequate to support coordinated delivery of needed services to patients by multiple independent providers. Therefore, ARCH works with the HCH and ARCH Interdisciplinary Care Teams to develop a locally aligned, cloud-based rural health information network (RHIN).

The RHIN will be populated with pertinent patient health information and data from both ARCH providers and PrimeWest Health. The hub of RHIN is the ARCH HCH with information-sharing spokes extending to ancillary and referral ARCH providers. Once approved by the State, ARCH providers can quickly access the secure cloud-based patient health information through the “SmartID,” a new information-sharing technology developed by PrimeWest Health. Using this new technology, providers will have real-time access to the patient information they need to provide appropriate care. At a minimum, the ARCH RHIN allows the HCH to do the following:

- More effectively monitor and manage patient compliance with care/treatment and medication therapy management plans
- Be promptly notified of potential inappropriate or unnecessary use of health care services
- Be promptly notified of a patient health event that might otherwise go unreported to the primary care provider

Reporting and claims data access

PrimeWest Health provides the ARCH HCH with quarterly interim reports and annual year-end reports regarding shared savings, measured service categories, and provider performance scores. The ARCH HCH can also access provider and claims information through a secure web portal that allows providers to create additional ad hoc and/or customized standard reporting packages per their identified need.
Accountable Rural Community Health (ARCH) Process Overview

- Minnesota Health Care Programs (MHCP) members
- HCH selection
- HRA and screening by HCH and ARCH ICT
- Triage by HCH and ARCH ICT
  - Chronic disease and complex care pathway
  - Behavioral health (mental health and/or chemical dependency) pathway
  - Integrated physical and behavioral health pathway
  - Wellness and prevention pathway
  - Acute condition health care pathway
- Patient-centered care plan development and care management (member/family, HCH, ARCH ICT)
- Treatment/care plan and other covered service delivery
- Payment for service delivery and care management
- Triple Aim objectives
- Pay-for-performance and shared savings payment

**LEGEND**

- HCH = Health Care Home
- HRA = Health Risk Assessment
- ARCH ICT = ARCH Interdisciplinary Care Team
Care Coordination

In addition to provider integration, care coordination is critical in avoiding duplication of services and fragmentation of service delivery. While specific care coordination activities will likely vary by HCH and patient circumstances, ARCH care coordination incorporates evidence-based care, complex care, and disease management programming. The HCH collaborates with the member and ARCH Interdisciplinary Care Team to achieve the objectives of the care coordination program, which include:

- Optimal clinical outcomes
- Better functional status/outcomes
- Improved patient and provider satisfaction
- A reduction in inappropriate utilization of health care resources and services
- Fewer preventable illnesses, hospitalizations, and unnecessary health care costs

ARCH follows a proven process and workflow that the HCH and ARCH Interdisciplinary Care Teams can adapt to fit the unique attributes of their organizations, patient populations, and local service area. The Accountable Rural Community Health (ARCH) Process Overview demonstrates how ARCH care coordination fits into the overall process.

The key steps of ARCH care coordination are health risk assessment, triage, care planning and care plan development, and care plan compliance and monitoring.

Health Risk Assessment – The member completes the Health Risk Assessment (HRA) shortly after enrolling in PrimeWest Health or experiencing a significant health care event. The HCH and county case manager then review the HRA results with the member. In addition, PrimeWest Health encourages and supports the use of many State and industry-approved screening tools and assessments that help providers identify specific member needs.

Triage – The HCH and member determine the individual health management pathway (treatment plan) most appropriate for the member based on the results of the HRA and other assessments/screenings deemed necessary by the HCH provider. The development of the treatment/care plan pathway includes setting goals and expected outcomes that are measurable and time-limited. Pathways may include:

- Chronic Disease and Complex Care – Involves the application of accepted disease management, complex care, and evidence-based clinical guidelines and practices, services, and activities
- Behavioral Health – Emphasizes mental health care management, chemical dependency treatment and management, and management/treatment of co-occurring mental health/chemical dependency problems
- Physical/Behavioral Health Comorbidity – Involves hybrid care planning and delivery to account for and address co-occurring physical and behavioral health morbidities
- Wellness and Prevention – Applies to members in good health with low health risks. The ARCH HCH and the member may choose to develop a plan of wellness and prevention activities and services to help the member maintain his/her good health.
Care Planning and Care Plan Development – The member, member’s family, HCH, and county case manager jointly develop a care plan. The plan is developed based on the assessment and other screening results and the care management pathway selected. While HCHs may implement their own industry-accepted standards in care planning, ARCH includes several nationally recognized and community-accepted clinical guidelines that HCHs and ARCH Interdisciplinary Care Teams can draw upon during care planning and care plan implementation.

Care Plan Compliance and Progress Monitoring – Once the care plan has been developed and implemented, the final steps in the process are to ensure patient compliance and monitor the ongoing progress of the member.

- **Service Delivery** – PrimeWest Health reviews and then prior authorizes care plan services and providers, thus ensuring unimpeded and timely access to appropriate covered benefits for the member. Care and service delivery are coordinated by the HCH care coordinator with utilization monitoring and review support from PrimeWest Health.

- **Self-Management** – The HCH and county case manager instruct the member about his/her responsibilities in managing his/her own health and well-being. This step seeks to foster member trust and motivation so the member will comply with and follow through on all facets of his/her care plans—including making efforts to stay healthy. These efforts are reinforced through member and provider incentives designed to motivate greater personal responsibility. Member incentives include those that the member finds personally motivating and are compliant with regulatory requirements.

- **Member Contact** – The county case manager and/or HCH maintain regular contact (touches) with the member to ensure care plan compliance and timely access to care coordination. This includes case management and disease management integrated with the HCH.

- **Health Information Exchange** – The HCH, ARCH Interdisciplinary Care Team, county case managers, and PrimeWest Health share relevant information regarding the individual’s care and treatment through the RHIN.

- **Measurement** – ARCH allows the HCH to continuously evaluate and monitor progress toward care plan goals, pay-for-performance objectives, Triple Aim objectives, and utilization data directly affecting the HCH’s shared savings or risk arrangement. This is accomplished in part through PrimeWest Health’s web-based electronic care plan. The electronic care plan provides an archival and real-time information-sharing platform to support appropriate and timely delivery of care plan services and more readily monitor member and provider progress toward care plan objectives.
Realigning Financial Incentives

Triple Aim cannot be achieved under the predominantly fee-for-service (FFS) provider reimbursement system in place today. For example, in the scenario given in *Hospital Admission Reduction Management Process for Ambulatory Care Sensitive Conditions (ACSC) – Congestive Heart Failure (CHF)* (see page 15), FFS offers little if any financial compensation for providers to prevent an emergency room visit or inpatient admission for CHF. This applies to most other acute or chronic conditions as well. Indeed, the chart on page 15 is a diagram for financial loss under FFS since it would result in fewer and less costly services, thus less revenue.

Under Triple Aim, however, failing to prevent a CHF hospitalization would also mean failing to meet two of the three Triple Aim objectives. ARCH uses several alternative provider compensation and reimbursement strategies in addition to FFS to provide the financial motivation and resources necessary to achieve Triple Aim. These strategies include capacity development grants, care management compensation, pay-for-performance bonuses, and shared savings on the total cost of care for the provider’s attributed PrimeWest Health patient population.

**Capacity Development Grants**

An ARCH Capacity Development Grant is provided to the ARCH HCH to implement care integration and pursue the Triple Aim objectives. Grants are intended to help recipients do the following:

- Execute an MOU with local public health and social services agencies to integrate provision of community based services into the care plan and coordinate care management efforts
- Establish and document a process for ARCH Interdisciplinary Care Team collaboration
- Demonstrate internal care management processes
- Develop patient registries for high-risk or chronic conditions
- Establish a data sharing agreement with a State-certified Health Information Exchange (HIE)

**Care Management Compensation**

PrimeWest Health pays the ARCH HCH a monthly per member per month (PMPM) care management subsidy for conducting care management activities and meeting various community and quality standards (see *Examples of Care Management Process Elements* on page 17), including member satisfaction benchmarks. The PMPM is applied and risk-adjusted to the HCH’s entire attributed PrimeWest Health patient population regardless of their care management requirements or needs.
Hospital Admission Reduction Management Process for Ambulatory Care Sensitive Conditions (ACSC) – Congestive Heart Failure (CHF)

Congestive Heart Failure (CHF) is an Ambulatory Care Sensitive Condition (ACSC) that often results in preventable yet costly hospitalization and/or emergency room encounters when not treated properly in the outpatient setting. This chart demonstrates how ARCH care coordination could be used to prevent an inpatient readmission and/or emergency room encounter due to CHF.
**Pay-for-Performance Bonuses**

The ARCH HCH and PrimeWest Health may jointly develop pay-for-performance projects designed to address specific local health and/or human services issues or conditions negatively affecting efforts to achieve Triple Aim for the designated member population. ARCH pay-for-performance projects must include other local providers involved in or affected by the issue that the pay-for-performance project is intended to address, such as long-term care, continuing care, and mental health providers.

**Shared Savings on Total Cost of Care**

Prior to implementing ARCH, PrimeWest Health develops and presents a detailed health care utilization and cost profile to the ARCH HCH. The “ARCH Community Profile” is designed to provide the HCH a realistic view of the shared savings and pay-for-performance bonus potential of the designated member population. The profile is based on historical utilization and cost data from PrimeWest Health members in the HCH’s service area. The profile will identify potential short- and long-term utilization improvement and cost containment opportunities for the HCH. These will include services and costs that can plausibly be reduced through improved care management and service delivery coordination.

Once ARCH is implemented, the HCH is paid a share of the financial savings if overall health care, public health, and social services costs are reduced while quality is improved. Savings will be determined by comparing the current year’s expenditures to the previous year’s. Normalizing adjustments will be made for shifts in population, patient morbidity, covered benefits, and fee schedules to ensure that results are compared fairly and consistently. All member populations are encompassed in the model.

The shared savings model is based on the total cost of care for the designated member population, meaning all health, wellness, and human services are covered by PrimeWest Health, including, but not limited to: medical, dental, behavioral health, transportation, medical supplies and durable medical equipment (DME), pharmacy, long-term care, and home and community based or “waiver” services. By being inclusive rather than exclusive, ARCH aligns incentives to focus on all elements of the member’s complete care and well-being and provides the HCH and other accountable providers with the best opportunity to realize shared savings and pay-for-performance incentives through their care management actions and decisions.

The HCH provider portion of savings ranges from 15 – 50 percent of the reduction in the total cost of care (total savings). Providers can increase their percentage of the savings if they also accept a proportional percentage. How the HCH’s share of the savings is shared with other providers such as the ARCH Interdisciplinary Care Team is determined by the HCH.

PrimeWest Health will provide HCHs and other accountable providers with the reports and data they need to measure progress toward pay-for-performance and shared savings objectives via a secure web-based information-sharing platform tied to the HCH’s RHIN.
### Community Standards

1. Appointment timeliness and access to care standards are met
2. Needs are assessed and identified on the member care plan according to Health Risk Assessment (HRA)/Long-Term Care Consultation (LTCC) and other screening tools that include cultural and disability sensitivity in patient interactions
3. Care plan updates are communicated to patients in a timely manner
4. Information is communicated among providers when referrals are made
5. Patients are given input into treatment plan
6. Health record standards such as patient identifiers, problem list, medications, Advance Directives, allergies, etc., are included in the patient’s medical record.
7. Patients are provided with continuity of care and appropriate community and social services
8. Patient information is protected and handled in a confidential manner
9. Patients are not discriminated against based on their gender, ability to pay, etc.

### Structure and Process Measures

1. Written policies and procedures specifying the elements identified as existing community standards are on file, current, and available for audit
2. Access to medical records and personal interviews is provided to substantiate conformity to policies and procedures
3. Prior authorization requests are submitted in a timely manner with necessary supporting information
4. Response to CMS regulatory changes on a timely basis
5. Cooperation with all providers on elements that may not be the sole responsibility of the clinic, such as audits

### Quality Measures

1. Improve follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication
2. Improve antidepressant medication management for patients age 18 and over
3. Improve medication reconciliation
4. Improve management of high-risk medications
Supporting Success
Total Cost of Care Continuing Education

ARCH providers, especially HCHs, may desire ongoing education and support to help effectively implement and manage total cost of care. Therefore, ARCH includes total cost of care workshops and technical assistance programming. This includes, but is not limited to, education on reports, data analytics, Health Effectiveness Data and Information Set (HEDIS), health informatics, chronic disease management, and other topics at the ARCH provider’s request. Such programming is intended to develop a rural health care learning community to promote the adoption of effective health system improvements through strategies focused on the needs of rural populations. This type of information sharing is essential to continuous improvement in patient experience and health outcomes and the evolution of accountable care. It is anticipated that the ARCH HCHs, Interdisciplinary Care Teams, and PrimeWest Health will all gain new insights from this learning experience, sharing data and perspectives about patient care, costs, and outcomes.

Evolving ARCH

To be successful in achieving Triple Aim, ARCH must be adaptable to changing providers, health care systems, patient populations, and regulatory policy. While certain ARCH building blocks cannot be removed, such as the HCH keystone, processes and the arrangement of the blocks need to be mutually monitored and evaluated for effectiveness and then rearranged as necessary by the HCH, ARCH Interdisciplinary Care Team, and PrimeWest Health to ensure progress toward achieving Triple Aim.

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