

Supporting “Meaningful Use” of HIT in Small, High-Volume Medicaid Practices

Technical Assistance Brief

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The American Recovery and Reinvestment Act of 2009 (ARRA) provides significant federal funding for Medicaid and Medicare electronic health record (EHR) provider incentive programs. The legislation attempts to harness the promise of health information technology (HIT) to transform the health care delivery system. Small, high-volume Medicaid providers are a primary target of the funding. As such, there are substantial opportunities for Medicaid agencies to help small practices in implementing EHR incentive programs.

A significant percentage of Americans, including many low-income and racially and ethnically diverse Medicaid beneficiaries, receive primary care from small practices. Approximately 60 percent of physicians (either self-employed or in physician-owned groups) work in practices with four or fewer providers,¹ and roughly 65 percent of physician office visits occur in practices of this size.² In select states, approximately half of Medicaid managed care beneficiaries are served by practices with three or fewer providers, and one-quarter are served by solo practices.³ Small practices typically have fewer resources — limited staff, financial reserves, and quality improvement tools such as HIT — to provide high-quality patient care.⁴

Early lessons in helping small practices overcome these challenges, transform day-to-day processes, and adopt HIT can help states prepare Medicaid providers to take advantage of ARRA’s EHR incentives. Through the Center for Health Care Strategies’ (CHCS) *Reducing Disparities at the Practice Site* initiative, four states are testing the leverage that Medicaid agencies and their contracted health plans have to improve care for patients with diabetes in these practices, largely by supporting implementation of electronic registries.

Purpose of this Brief

This brief describes how Oklahoma, Michigan, North Carolina and Pennsylvania are, through *Reducing Disparities at the Practice Site*, supporting practice improvements among Medicaid-serving providers by helping them to adopt and implement electronic registries. These tools are critical to helping practices efficiently manage their patient population, identify gaps in care, and measure and track improvements in quality. The experiences of the four state teams are useful to states looking to adopt similar strategies. The following case studies describe how each team: (1) chose and funded a registry; (2) engaged practices; (3) populated the registry; and (4) used it for ongoing quality improvement. The brief concludes with common lessons across the states.

Notably, at program launch in 2008, the teams decided to support registries, rather than EHRs, in the targeted practices. They viewed registries as a solid, although interim step, towards EHR adoption, and a valuable tool to learn performance measurement, identify care gaps, and track and improve quality. With the passage of ARRA and the EHR provider incentive program, states are considering how registries can evolve into meaningful EHR use.

Electronic Registry Implementation: State Examples

Oklahoma

The 10 practices participating in Oklahoma's *Reducing Disparities at the Practice Site* project are implementing CareMeasures, a web-based patient registry designed by the Iowa Foundation for Medical Care (IFMC). CareMeasures captures data and calculates performance for patients with a chronic condition, allowing practices to monitor the care and disease status of each patient. Practices learned to enter patient data from charts, use patient summary pages for individual patient visits, and generate reports that aggregate patient data into performance measures.

From the very first discussions with target practices, the team described the registry and the importance of regularly tracking data. Practice facilitators spent considerable time educating practice staff (e.g., receptionist, office manager, etc.) about chronic disease measurement, and creating a quality improvement culture.

To drive home the value of the registry, the practice facilitator initially has the practice conduct a self-assessment of its performance in diabetes care. At the same time, the practice facilitator does an initial chart abstraction using practice data to calculate actual performance. The facilitator and practice then compare and contrast their findings. This exercise rarely fails to support the case for a more systematic, automated approach to managing the patient panel.

To implement the registry, IFMC staff remotely load the CareMeasures tool onto the practice's system and front-load basic demographic data (e.g., name, race/ethnicity, etc.) and billing information on diabetic patients from the Medicaid agency. These staff handle all of the technical web-application issues, leaving the practice facilitator to focus on quality. The practice facilitator then pulls charts for members and enters data for each diabetic patient to identify any care gaps and calculate performance measures. To calculate a measure, the facilitator enters at least two visits, but can go back one year, as needed. The level of effort varies significantly — some practices have 10 or fewer diabetic patients, while others have more than 100. Results are shared with the practice.

The practice facilitator teaches the staff to adopt a continuous quality improvement perspective. For example, after the practice has developed a process to populate and use CareMeasures, the practice facilitator will explore any glitches in the process, help the team test small changes, and assess the impact. Practices vary widely in their adoption and meaningful use of the tool: some use it sporadically or not at all, while champions in other practices have embraced it.

Notably, CareMeasures overlaps with the clinical measurement set for EHR meaningful use by primary care providers. Practice facilitators are educating practices about the incentive program, and the state is considering strategies to pair small practices in mentoring relationships with larger clinics that have already implemented HIT. Looking ahead, an interface platform is being developed to connect CareMeasures with EHRs, eliminating duplicate data entry requirements.

About *Reducing Disparities at the Practice Site*

CHCS developed *Reducing Disparities at the Practice Site* to support quality improvement in small practices serving a high volume of racially and ethnically diverse Medicaid beneficiaries. The three-year initiative, launched in October 2008 with funding from the Robert Wood Johnson Foundation, is testing the leverage that Medicaid agencies, health plans, primary care case management programs, and other community-based organizations have to improve chronic care in small practices serving this population. State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania are building the quality infrastructure of 40 high-volume primary care practices that together serve 53,000 Medicaid patients. The teams are supporting practice efforts to improve chronic care by:

- Assessing each practice's needs and priorities for improving care delivery;
- Identifying and tracking the care of diabetic patients through electronic registries;
- Deploying practice-based quality improvement coaches and/or nurse care managers to support practices in redesign and care management; and
- Providing financial support for each practice's time and effort.

Michigan

The Michigan team includes six Medicaid health plans that are aligned around a common set of quality improvement interventions at the point of care in six small practices. To be eligible, a practice must contract with at least five of the six participating plans. Each practice is supported by a “practice buddy”— a quality improvement expert from one of the plans who works with the practice on behalf of all six plans. The practice buddy plays many roles, including coach, trainer, quality improvement /performance measurement expert, and “cheerleader,” as the practice strives to implement and use an electronic registry and be positioned to achieve designation as a patient-centered medical home by the National Committee for Quality Assurance.

The team played a pivotal role in introducing the six participating practices to HIT: identifying popular electronic registry tools used by the local provider community, vetting the products by functionality (specifying “must-have” functions), and presenting the practices with the choice of two products. Any practice with a preferred electronic registry tool in place could still receive quality improvement and performance measurement support from the practice buddy. The plans each contributed funding for the product, including training and ongoing technical assistance from the vendor (though each practice holds the contract with the vendor).

To populate the registry initially, the plans gave the vendors one aggregated member eligibility file (with patient demographic data) for each practice. The vendors then uploaded the appropriate member file into each practice’s registry. The vendors are developing interfaces with other providers, such as labs and ancillary providers, to populate the tools on an ongoing basis.

Once the registry is loaded, the practice buddy works one-on-one with the practice on ongoing data input, creating reports and using performance measures to track quality. The plans developed a common financial incentive program, linking payments to meaningful use of the registry for management of diabetic patients. They defined meaningful use as: (1) pulling registry reports; (2) using evidence-based flow sheets for diabetes care; (3) generating reminders; and (4) issuing patient recall notices.

North Carolina

North Carolina’s Medicaid program includes 14 regional networks that provide care management for the state’s beneficiaries. Through *Reducing Disparities at the Practice Site*, Carolina Collaborative Community Care (4C) — one of the regional networks — partnered with *Improving Performance in Practice (IPIP)*⁵ to support registry implementation and use. A state-based, nationally led quality improvement initiative, *IPIP* is deploying coaches to work directly with 12 participating practices. By spring 2010, most of the practices had completed training in the web-based *ReachMyDoctor*⁶ registry, and were entering data independently.

IPIP provides standardized training from *ReachMyDoctor* — first online, then in lunchtime webinars. The coach supplements this by working individually with each practice. The practice contracts with *ReachMyDoctor*, and receives one license, paid for by *IPIP*. Additional licenses cost \$500 per physician.

Initial data entry occurs in a two-pronged process. Each practice designates a staff person to input demographic data for diabetic patients, either incrementally or all at once, depending on the number of diabetics. Medical assistants or receptionists then enter clinical and care plan data for each patient at each office visit.

IPIP coaches must have two contacts monthly with each practice; frequency varies based on a practice’s need and the extent of data entry into its registry. During these contacts, the coach discusses practice performance, comparing baseline data to performance after three months of registry use. The mutual goal is a 10 percent improvement after each three-month period.

The coach also checks the integrity of the data. With support from a state clinician, the team examines whether, for example, the total number of diabetics captured in the registry appears reasonable or is likely

incomplete. Performance rates are reviewed for reasonability, and data gaps or discrepancies are identified. The coach examines the denominator and numerator of the performance rates to make sure the practice is capturing the measures correctly.

Once the registry produces performance rates, *IPIP* work closely with a case manager from the state to address care gaps and quality improvement opportunities. The *IPIP* coaches work with each practice for 12 months, at which time the practices typically “graduate” and the coach moves to the next facilitation opportunity.

Pennsylvania

Pennsylvania’s multi-stakeholder, collaborative team is led by the Department of Public Welfare and the three health plans managing the care of Medicaid beneficiaries in Philadelphia. A full-time nurse care manager, hired by the state, works on behalf of all three plans to provide care management support and quality improvement facilitation to participating practices. The eight participating practices have four or fewer providers and 500 or more Medicaid patients.

The Department of Public Welfare used its leverage to create alignment with the Pennsylvania Chronic Care Initiative,⁷ which is seeking to build medical homes in targeted practices across the state. The Initiative provided the *ReachMyDoctor* registry at no charge to Medicaid and the practices participating in the initiative.

Pennsylvania introduced *ReachMyDoctor* to interested practices “early and often,” describing the registry at the initiative kick-off dinner. The nurse care manager reinforced the concept of the registry, performance measurement, and population management during individual “sales calls” to the practices. She explained the registry in simple words — describing its functions, usefulness, and required maintenance.

To demonstrate the registry, the nurse care manager worked one-on-one with a point person from each practice. The health plans supplied demographic and pharmacy data for diabetic members to the state’s quality improvement organization, which aggregated it for upload to the registry. When practices accessed the registry, they could immediately print out patient lists and identify care gaps.

The team found that getting practices up-and-running took significant, individualized and varied amounts of time and effort based on the computer skills within each practice. Several of the practices subsequently have begun to use the tool independently.

As the state considers opportunities presented by ARRA, it is determining how *ReachMyDoctor* use will prepare its provider community for EHR adoption. A key requirement will be data flow between *ReachMyDoctor* and the EHR application.

Lessons for HIT Implementation and Meaningful Use

Early lessons in promoting HIT in small practices are valuable for future EHR implementation.

- **Think globally, act locally.** Even though registries are implemented on a practice-by-practice basis, implementation, training and use should be global. For example, implementation schedules, registry population, training events, and vendor staff can be synchronized for a group of practices to begin registry use concurrently. This creates a peer group of practices, allows the facilitators/ coaches to better coordinate activities, and provides an opportunity for the vendor to leverage standardization across practices.
- **Fully understand registry features and functions.** Make sure that each registry is able to interface with other providers and to “push and pull” data to and from an EHR. This is particularly critical as practices shift to EHRs from registries.

- **Lead by example.** Coaches must be fully comfortable and experienced with the registry tool, as practices need a steady and confident teacher. This will increase efficiency and reduce frustration among facilitators and practices.
- **Use the vendor, not the practice coach, for “registry nitty gritty.”** The practice coach teaches a quality improvement culture, performance measurement, population management, and workflow redesign. The vendor can provide access to the tool, preload data, trouble-shoot problems with the technology, etc.
- **Make the case to practices. Then make it again. And again.** Spend considerable time — before registry implementation — explaining to the practices why the tool is worth their investment, how it will change care delivery, and how it ultimately will make the physician’s work more efficient and effective.
- **Plan for a six-month process. Then add at least six more.** Teams significantly underestimated the amount of time it takes for practices to implement, populate, and meaningfully use the registry. This is more likely when practices enter data themselves.
- **Make the connection with meaningful use.** All coaches are educating the practices on the upcoming EHR incentives, communicating that adopting and using registries meaningfully is a worthwhile step toward meaningful use of EHRs.
- **Be aware of practice overload.** After many years of feeling isolated and under-supported, primary care practices are suddenly receiving much attention, specifically from the growing number of medical home/practice transformation initiatives and Medicaid and Medicare EHR incentive programs. Teams providing coaching and supporting HIT adoption, implementation and meaningful use need a thoughtful strategy that will not overload these practices.

Conclusion

With support from practice facilitators and coaches, practices participating in *Reducing Disparities at the Practice Site* initiative are making valuable headway toward meaningful use of HIT and Medicaid incentive payments. The teams believe that “getting over the hump” of registry adoption, implementation and use will be invaluable toward preparing for these incentives. The teams’ strategies can inform other Medicaid programs, Regional Extension Centers, the Centers for Medicare and Medicaid Services, and the Office of the National Coordinator, as they strive to expand EHRs or meaningful use of HIT throughout the Medicaid provider network.

Related Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. The following resources can be found at www.chcs.org.

- *Reducing Disparities at the Practice Site* state profiles
- *Practice Transformation in Medicaid: Five Levers to Strengthen Small, "High-Volume, High-Opportunity" Practices*
- *EHR Incentive Programs for Medicaid Providers: How are States Preparing?*

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Endnotes

¹ E. Hing, D.K. Cherry, and D.A. Woodwell. "National Ambulatory Medical Care Survey: 2004 Summary," *Advance Data* 374 (23 June 2006): 1-33.

² C. Kane, . *Physician Marketplace Report* (Chicago: American Medical Association, Center for Health Policy Research, 2001).

³ J. Moon, R. Weiser, N. Highsmith and S.A. Somers. *The Relationship between Practice Size and Quality of Care in Medicaid*, Center for Health Care Strategies. July 2009. Available at <http://www.chcs.org>.

⁴ M. Abrams, E.L. Schor, and S. Schoenbaum. "How Physician Practices Could Share Personnel and Resources to Support Medical Homes," *Health Affairs*, 29(6): 1194-1199.

⁵ For more information about *IPIP*, visit <http://www.ncafp.com/initiatives/ipip>.

⁶ For more information about *ReachMyDoctor*, visit <https://www.reachmydoctor.com/index.aspx>.

⁷ For more information about the Pennsylvania Chronic Care Initiative, visit <http://www.rxforpa.com/chroniccare.html>.