Michigan Reducing Disparities at the Practice Site (RDPS): Final Report

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Introduction

Michigan was one of four states selected to participate in the Center for Health Care Strategies (CHCS) Reducing Disparities at the Practice Site (RDPS) initiative. RDPS, launched in 2008, was a three-year project to test 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 the Medicaid population. RDPS focused on the critical role these organizations have in facilitating and sustaining improvements in care by providing practice sites with data, technology, care management resources, quality improvement training, and capital.

With 1.7 million Medicaid beneficiaries (1 million in managed care) and a well-established process for Medicaid and health plan collaboration, Michigan was an ideal site for RDPS. Key components of the Michigan RDPS project included collaboration between Medicaid, six Wayne County health plans, and six small, high-need practices.[1] Technical assistance was provided by the Michigan State University Institute for Health Care Studies and the University of Michigan. The Michigan team adopted a coalition approach and a focus on achieving patient centered medical home (PCMH) recognition for the practices by the end of the three-year project.

Program Goals and Components

The goal of Michigan's *Reducing Disparities at the Practice Site* initiative was to assist six small, primary care practices with a high volume of Medicaid patients in Detroit achieve certification from the National Committee on Quality Assurance's (NCQA) as a Patient-Centered Medical Home. The six participating practices serve more than 13,700 Medicaid patients (93 percent from racial/ethnic minority groups). Practice selection criteria were developed by the project team: less than or equal to four primary care physicians in adult practice; more than 60 percent minority patient population; contracted with at least four of the six participating health plans; and documented disparities in relevant primary care clinical measures.

To facilitate these goals and support the six practices, the Michigan team provided each practice with a per member per month (PMPM) financial payment for participation; funded, implemented and provided technical support for a patient registry in each practice; and provided each practice with ongoing technical assistance in quality improvement and PCMH.

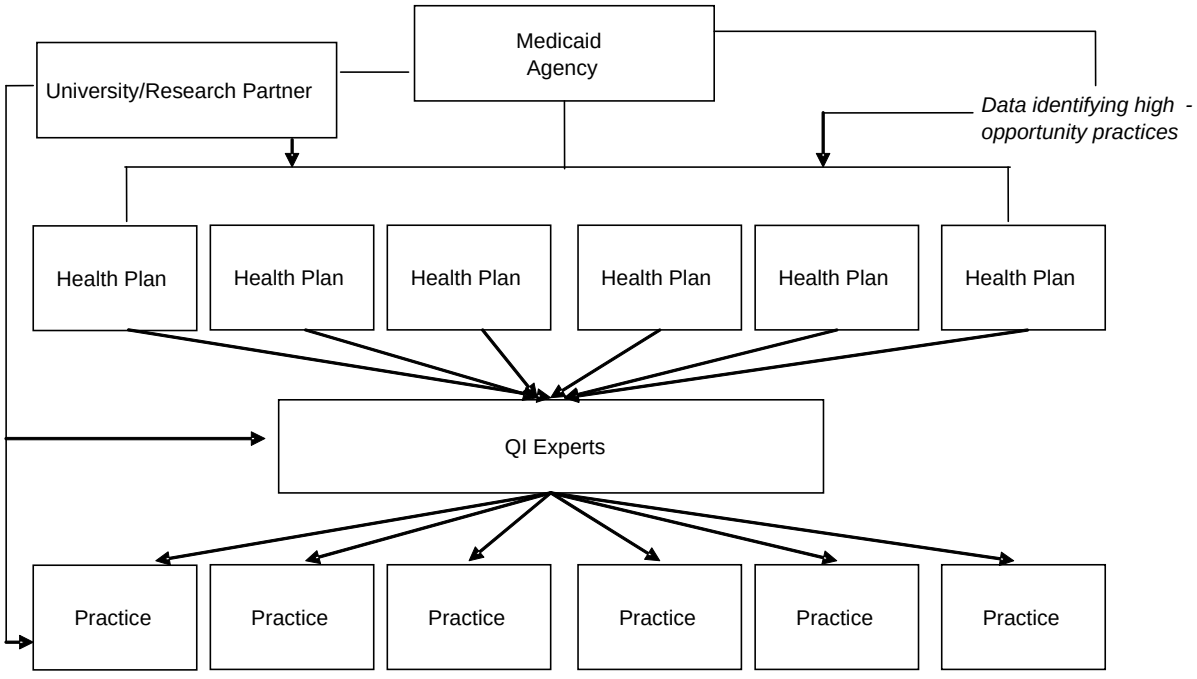
[1] One practice was located in a larger clinic setting.

Team Structure

Michigan's team (see Figure 1) was led by the Michigan Department of Community Health's Bureau of Medicaid Program Operations and Quality Assurance with support from Michigan State University's Institute for Health Care Studies. The core stakeholders included six Medicaid plans that contract with the practices: Meridian Health Plan (formerly Health Plan of Michigan), Molina, UnitedHealthcare Community Plan (formerly Great Lakes Health Plan), Midwest Health Plan, OmniCare, Total Health Care; the Greater Detroit Area Health Council (GDHAC); the University of Michigan (CHEAR); and local public health organizations.

Each health plan provided a dedicated quality improvement expert to work with the practices. Each QI expert outreached to and engaged an individual practice, conducted a practice assessment, and provided support around PCMH elements. While employed by a specific plan, the QI expert represented the coalition of the six plans.

Figure 1. Team Structure for Michigan Project



Engagement and Assessment of High-Opportunity Practices

Practices were identified for potential participation after analysis of Medicaid claims and encounter data. Each practice meeting criteria for participation and agreeing to join the project signed a memorandum of understanding.

After the memorandum of understanding was signed but prior to interventions, the Michigan team adopted a three-part practice assessment. Practice assessments were performed by the health plan QI experts using the Assessment of Chronic Illness Care (ACIC) tool developed by the MacColl Institute for Healthcare Innovation, the National Committee for Quality Assurance (NCQA) PPC-PCMH self-assessment tool, and questions assessing the administrative practices and culture/organizational leadership of the practice. Results from the assessment, including an approximation of PPC-PCMH recognition readiness, were scored and entered into a project database. Findings were shared with each practice and with all Michigan team members. At the conclusion of the initial assessment, it was determined that three practices approached Level 1 PPC-PCMH readiness and no practices were fully qualified for PPC-PCMH recognition.

At the onset of the project, the Michigan team determined the initial RDPS focus would be on diabetes care. This decision was based on the state's clinical focus on diabetes, the availability of evidence-based guidelines for diabetes care, and existing HEDIS measures.

Evaluation Plan

To assess the extent to which RDPS goals would be met, Michigan's evaluation employed structure, process, and outcome measures. Using pre- and post-implementation data, we proposed analyzing the impact of the project against the following objectives:

- Capturing relevant patient-level data and implementing registries in primary care practices
- Making actionable data available at the point of care
- Using registries to trigger evidence-based interventions and to generate reminders/recalls
- Assessing trends in diabetes services delivered to patients in the practices
- Transforming primary care consistent with the PCMH model

Interventions

Practice Support

One of the most unique components of the Michigan RDPS initiative was the development of a shared, multi-payer incentive model. During the design phase of the project, the six Medicaid health plans agreed to support the six practices with financial incentives of $0.50 PMPM for participation that was matched by RDPS grant funds, for a total of $1 PMPM. Payments were provided at specified intervals throughout the project. Payments varied according to the size of each practice's Medicaid patient panel. As of June 2011, the six participating practices received incentive payments (funded by Medicaid health plans and RDPS) totaling $400,433.00.

Registries: Identifying and Tracking Diabetic Patients

The Michigan team explored numerous registry products, focusing on the tools most commonly used by providers for effective population management in the PCMH. Based on that research and subsequent demonstrations with registry vendors, the team identified two products that would meet project goals (Cielo and WellCentive). Necessary functions included tracking

unlimited conditions/prevention/wellness for individual patients and populations; reminder/recall functions; population-based reporting; stratification; tracking race/ethnicity/primary language and how patients prefer to be contacted; guideline based decision support tools; generates prompts, flow sheets, and chart forms; tracking labs/tests/preventive services; and ease of use/training/IT support. At the end of the project, two practices were actively using registries for population management, including one practice that continued to use a registry that had been built internally and was in place prior to the onset of RDPS.

Practice Redesign: Providing QI Supports and Strategies

As previously described, each practice worked with an assigned quality improvement expert from one of the six health plans to develop a work plan reflecting the practice's project priorities. Each QI expert represented Medicaid and the coalition of participating plans. Specific activities conducted by the practice buddies included regular meetings with the practices, health plans, project team, and CHCS; review and management of project timelines; identification of health plan issues; providing practice-level technical assistance; and mediation of system-based registry issues with vendors. The importance of the practice buddies to the project cannot be overstated. These individuals were the face of RDPS for the Michigan team and the practices, and the monetary value of the technical assistance provided by the project/practice buddies was estimated at $50,000.

Practice Transformation

Practice transformation was an intended component of the RDPS project. Specifically, elements that the project team anticipated would be implemented in the practices included flow redesign, expanded access, staff role assignments, and administrative and billing improvements. These activities were scheduled to occur in year two through the end of the project. However, due to delays in the registry implementation and practices' perceived difficulties with PPC-PCMH complexity, transformation activities were not implemented as intended. During year two, the project team attempted to identify ways to jump start the transformational activities. Because of the efforts around PCMH and associated payer incentives that were occurring in Michigan at that time, a number of vendor start-ups were available to contract with practices and assist with PPC-PCMH. The Michigan RDPS team was approached by PRISM, a vendor with physician leadership and industrial redesign experts formerly employed by the auto industry. PRISM met with the project team and offered to work with practices on an individual basis, guaranteeing return on investment with a gain sharing model and no up-front cost to the practice. All of the practices agreed to undergo an assessment by PRISM; however, none of the practices chose to proceed with PRISM due to perceived intrusion in the office environment. The practices also perceived that the gain share would result in a potential loss of revenue.

In an effort to facilitate Michigan's practice transformation goals, CHCS arranged for consultation by Richard Baron, MD, MACP. Dr. Baron provided insight to the Michigan team

and participating physicians about the value of PCMH and effective population management; however, these discussions did not result in additional transformational efforts.

The practices elected to work with their practice buddies to develop improvement plans; however, minimal transformation efforts resulted from this approach.

Care Coordination

During year two, the Michigan team also spent considerable time and effort meeting with the practices to define care coordination and parameters for care management activities in the practices. The following definition of care coordination was adopted by the Michigan team:

> *Care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of (added: adults) children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.*[2]

Characteristics of care coordination were also defined as patient and family-centered; proactive, planned, and comprehensive; promoting self-care skills and independence; and emphasizing cross-organizational relationships. Care coordination competencies included developing partnerships, communicating proficiently, using assessments for interventions, extraordinary care planning skills, integration of resource knowledge, possessing goal/outcome orientation, using an adaptable and flexible approach, and adept use of information technology.

Michigan convened an all-team meeting specifically devoted to the discussion around care coordination and conducted a focus group of RDPS physicians to assess care coordination functions within their offices. As a result of that focus group, physicians felt that they were adequately performing care coordination functions (as defined), and none of the physicians were open to having external care coordinators embedded in their practices (even at no cost). Physicians felt that in-office care coordination was not only unnecessary but would be intrusive and result in barriers to established flow. The Michigan RDPS team determined that if embedded care coordination was to occur in these practices it would need to be revisited at a later date.

Evaluation Findings

As previously discussed, HEDIS® measures were selected based on project goals and objectives and were reported by site, in aggregate, and at the county level:

- Hemoglobin A1c testing
- Retinal eye examination
- Nephropathy
- LCL-C

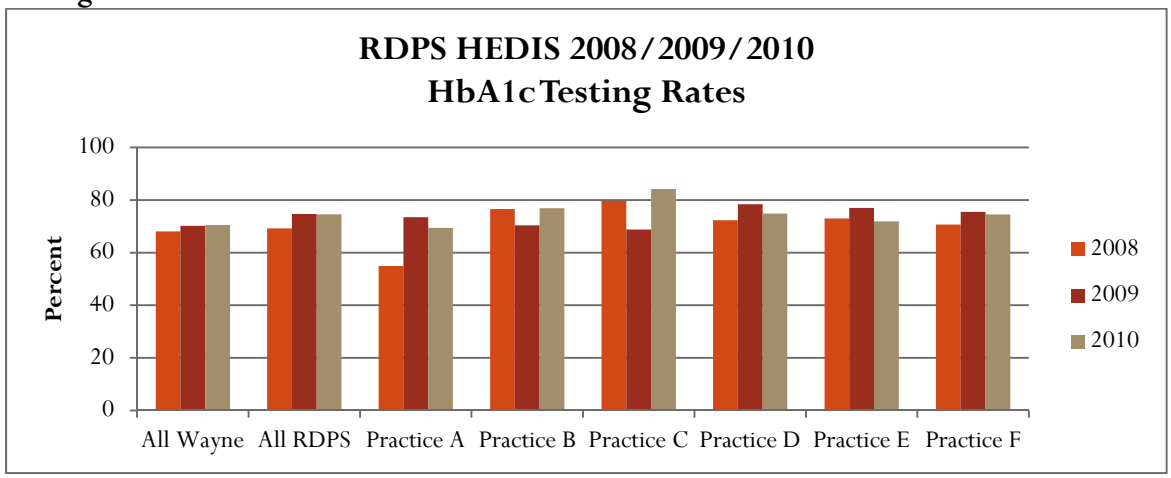
[2] Antonelli, McAllister, & Popp (2009). Measuring care coordination: Outcomes and needed measures. Commonwealth Fund.

These data were obtained from the Michigan Department of Community Health data warehouse (Medicaid claims and encounters) and were sent to the University of Michigan Child Health Evaluation and Research unit (CHEAR) for aggregation and analysis. Michigan was able to report at the practice level using methodology designed for a previous project funded by the Center for Health Care Strategies (Practice Size Exploratory Project, PSEP).

HEDIS® Data:

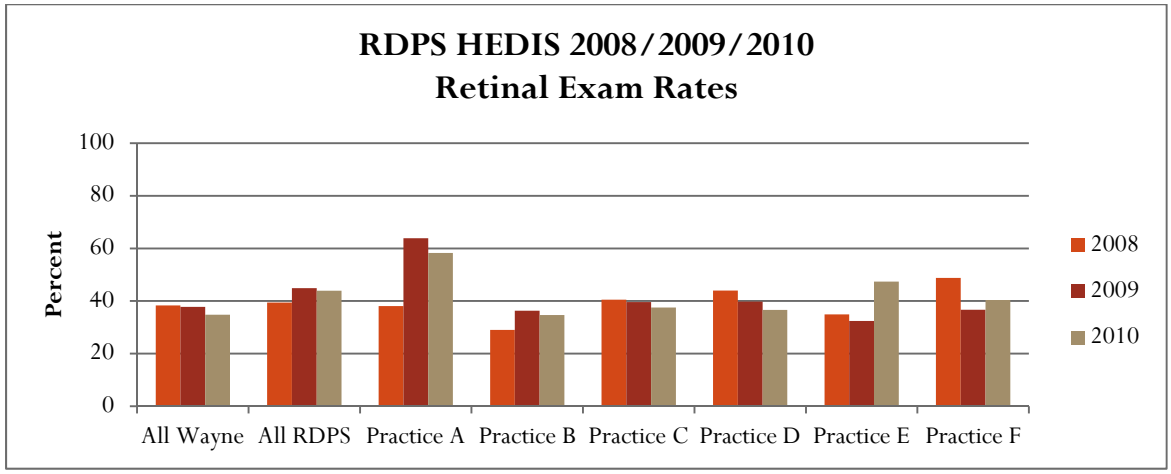
The following are results of HEDIS® measures for the RDPS practices and Wayne County for 2008-2010. Statistical significance was not calculated as a component of these findings.

Hemoglobin A1c:



With two exceptions, participating practices experienced improvements in hemoglobin A1c testing rates from year 1 to year 2. In year 3, two practices improved and the remaining four practices either decreased or remained unchanged. The combined RDPS practice rate for HbA1c testing increased from year 1 to year 2, was unchanged in year 3 and exceeded the Wayne County rate for both years.

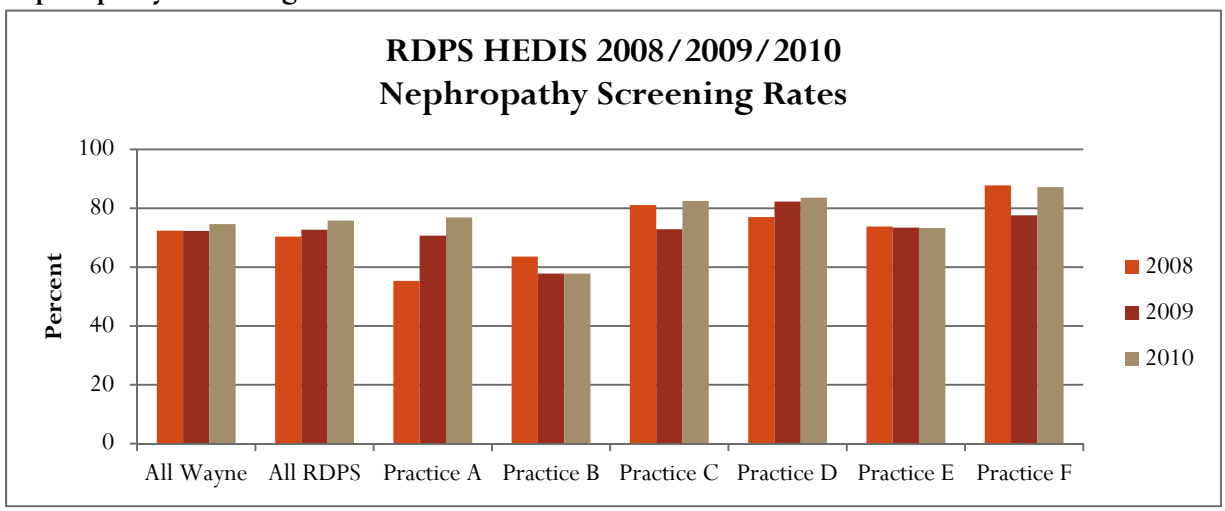
Retinal Exam:



Three of the participating practices experienced decreases in retinal exam rates from year 1 to year 2, while two practices experienced increased rates. In year 3, only two plans experienced increases from year 2, while the remaining four plans had decreased rates.

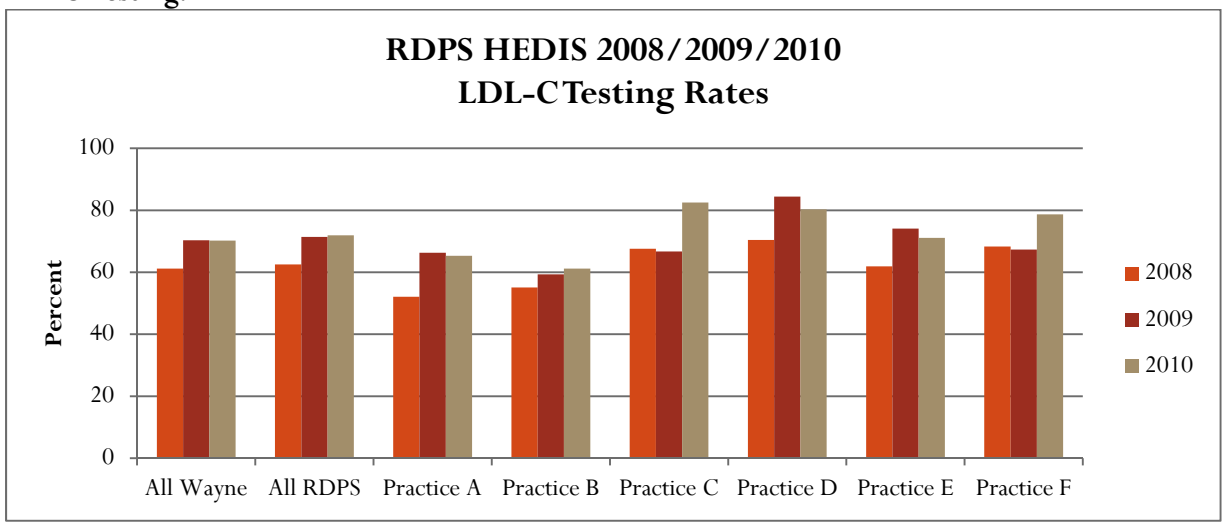
Overall, there was a slight increase in RDPS practice rates for retinal exams in from year 1 to year 2 and virtually no change from year 2 to year 3. The combined RDPS practice rate was higher than the Wayne County rate in 2009 and 2010.

Nephropathy Screening:



Two of the participating practices experienced increases in nephropathy screening rates from year 1 to year 2, while four practices experienced decreases. In year 3, three practices had increases and the remaining three were essentially unchanged. Overall, there was no appreciable difference between the Wayne County and combined RDPS nephropathy screening rates.

LDL-C Testing:



Four of the participating practices experienced increases in LDL-C testing from year 1 to year 2, while the remaining two practices remained essentially the same. From year 2 to year 3, three practices improved, two experienced decreases, and one remained the same. Overall, the RDPS combined rates approximate the Wayne County rates for all three measurement years.

PCMH Recognition:

As the result of the baseline RDPS practice assessment, it was determined that three practices approached recognition for NCQA Level 1 PPC-PCMH. By the end of the project, only one practice had achieved Level I PPC-PCMH recognition.

Additional Measures:

Focus discussions were conducted with practices around practice transformation, registry use, and care coordination. Clinic-specific cycle time and patient satisfaction were originally identified as project measures; however, data for these measures were not captured and reported as planned, because practices were largely unwilling to make transformational change.

Other Findings:

The Michigan RDPS team identified a number of factors impacting primary care transformation to the PCMH model during the course of the three-year project:

- The implementation of free-standing registries (i.e., not integrated in an electronic medical record system) was extremely difficult for these practices. This was a particularly important barrier for those practices affiliated with a physician organization or health system. Challenges for these practices included the lack of control over data flow from practice management systems, the lack of ability to automatically download data into the registry, the need to enter pertinent clinical data after visits at the point of care, and the lack of perceived value of registry use (despite financial incentives for implementation and continued assistance with initial registry data entry). In short, registries were viewed as expensive, difficult to implement, and lacking benefit to population management in the practices. Registry implementation was not perceived as a barrier in Michigan's one-physician practice; however, this physician did experience a resource shortage to complete registry data entry.

- Michigan's participating practices had varying levels of understanding about population management. In general, the practices tended to approach their populations as patients with a single condition of interest (in silos), rather than considering comprehensive health status including prevention, wellness, and comorbid conditions.

- Michigan's practices did not fully understand or accept the Patient Centered Medical Home as a model of care. In retrospect, the team may have introduced PPC-PCMH standards too quickly and comprehensively, causing the practices to be overwhelmed and resistant.

- Practice culture was the largest and most insurmountable barrier. Practices were most successful when the physician assumed a leadership role in practice transformation and PCMH.

- Practice staff education was a critical component to achieving project milestones; however, in the absence of physician leadership, staff education was not productive. Michigan did achieve some success in convening practice representatives in various roles (practice managers, billers, medical assistants, and physicians) and stimulating discussion within and among these groups.

- The coalition of health plans came together quickly as a cohesive group and remained effective throughout the initiative. This was evident not only in the way the plans worked together on elements of PCMH and practice transformation, but also in the unique shared incentive program that was developed in year one. This shared incentive was jointly administered by the plans and Medicaid and was a key component of the Michigan RDPS strategy.

- NCQA standards are complex; it would be difficult for practices to achieve recognition without technical assistance.

Additional Discussion

At the conclusion of the project and to validate the RDPS experience, the Michigan team sought approval from CHCS to attend the National Medical Home Summit and Population Health/Care Coordination Colloquium. The content of this conference, which was held in Baltimore, Maryland in February 2012, was specifically related to all aspects of the Michigan RDPS experience. Stated learning objectives included giving participants an understanding of the systems and tools necessary to work successfully with population health models, processes, staffing, training, patient engagement, and reporting. This was a course intended for professionals to analyze and understand the translation of population health issues in the context of local settings, which was clearly beneficial to Michigan's RDPS goals.

The final Michigan RDPS team meeting was held at the Summit. At that meeting, the team debriefed all aspects of the Michigan RDPS experience, including project successes and barriers:

- Practices were not fully engaged, although the team agreed a comprehensive practice assessment had been conducted and letters of agreement were obtained. It should be noted that the Michigan RDPS project evolved with a focus on PCMH, and the practices perceived this as a change from the original agreement. Strengthening expectations for performance/ participation and linking these expectations to financial incentives in a more specific way could have improved engagement.

- The evolution of the project emphasis on PCMH reduced the specific emphasis on disparities.

- Registry implementation was the first intervention. The team felt this was necessary due to the critical importance of registries for effective population management and PCMH. However, the time frame for registry selection, implementation and adoption was prolonged. This negatively impacted forward progress on other critical components of PCMH, such as care coordination.

- Participating practices were not supportive of embedded care coordinators. This was determined through focus groups, ongoing discussions, defining components of care coordination, etc. Practices felt that based on current definitions, they were performing care coordination functions and did not agree that the value added by in-house care coordinators would offset the inconvenience to practice flow, even if care coordinators were funded by the project or the participating health plans.

- The project team intended to address community resource integration; however, this component was continually deferred due to the barriers in other areas of PCMH. The Michigan team did not specifically address community resources beyond those already available and used by the participating practices. Community resource integration was not included in any incentive payments.

- Although all components of the Michigan RDPS work plan were not achieved, the Michigan team feels strongly that the project resulted in increased knowledge and positively contributed to other PCMH and population management activities. The health plan medical director who was a physician champion throughout the project indicated his health plan was using RDPS as a basis to design current plan PCMH activities (e.g., performance bonus, incentives, quality improvement activities).

- RDPS practices were also identified for subsequent inclusion in the Southeast Michigan Beacon project, and four of the six practices are participating with Beacon. MDCH is also a CMS multi-payer collaborative site through the Michigan Primary Care Transformation Project (MiPCT). RDPS initiated shared incentive pools across six Medicaid health plans, which contributed knowledge for the development of the MiPCT practice payment structure.

- RDPS also contributed to the selection of PCMH as a component of the Michigan Medicaid health plan performance bonus. The FY 2012 performance bonus focuses specifically on Medicaid health plan support for care coordination at the primary care practice level.

Conference attendees agreed the Medical Home/Population Management Colloquium program content reinforced the overall purpose and content of RDPS.

As a result of RDPS, Michigan Medicaid is able to fully participate in PCMH activities at the federal and state levels, contracted Medicaid health plans are using RDPS as a foundation for PCMH projects, and participating practices are better prepared to participate in PCMH

programs that may contribute to increased practice revenue. For the Michigan team, RDPS served the important function of introducing PCMH, resulting in early barrier identification, resolution, and subsequent adoption of primary care transformation.