

Key Factors for Improving Care Delivery in Small Primary Care Practices with High Medicaid Volume

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Small practices play an important role in caring for Medicaid beneficiaries. In some regions of the country, as many as half of Medicaid beneficiaries, including many who are racially and ethnically diverse are served by primary care practices with three or fewer providers.¹ Yet many disparities in access and quality of care exist in these practices.²⁻⁵

Despite the need to improve quality of care, small practices serving low-income populations are typically the last practices to be engaged in quality improvement programs, if at all. Small practices serving large numbers or percentages of Medicaid patients are often under-resourced, disenfranchised from the larger health care system, and isolated from other providers and quality improvement initiatives. The challenges of engaging providers who often lack the technology, staff, and infrastructure needed for effective chronic care management are daunting, as are the difficulties of developing a sustainable practice improvement model to address their needs. While these small practices are likely aware of the primary care medical home (PCMH) model and electronic health records (EHRs), actual adoption of these innovations is likely to be overwhelming due to lack of knowledge, staff capacity, and financial resources.

Through the Affordable Care Act, up to 11 million additional Americans may be eligible for Medicaid in 2014.⁶ As the largest health care purchaser in the country, Medicaid has an opportunity to ensure that under-resourced practices serving low-income and diverse patients do not “get left behind” as the delivery system transforms.

This brief examines key findings from *Reducing Disparities at the Practice Site* (RDPS), a three-year initiative made possible by the Robert Wood Johnson Foundation, to help states support small provider practices in delivering more efficient and higher quality care for low-income patients. The lessons from RDPS can help inform state Medicaid agencies and health plans in shoring up the primary care foundation within their own states.

IN BRIEF

Small primary care practices play a critical role in caring for low-income individuals with chronic conditions, particularly patients who are racially and ethnically diverse. *Reducing Disparities at the Practice Site* (RDPS), a three-year initiative funded by the Robert Wood Johnson Foundation, was developed by the Center for Health Care Strategies to support quality improvement in small practices serving this high-need population.

This brief presents key findings from an evaluation of the RDPS initiative and takeaways for Medicaid stakeholders. The initiative confirmed that Medicaid agencies must provide the vision and leadership for quality improvement investment in these critical, but often forgotten practices. Furthermore, health plans, primary care case management programs, external quality review organizations, and other community-based organizations must play a critical role in working directly with these practices to improve chronic care management and reduce disparities in care. Lastly, Medicaid investment in supporting these practices requires a long-term commitment to address the medical, behavioral, and social needs of their patient population.

About Reducing Disparities at the Practice Site

RDPS was developed by the Center for Health Care Strategies (CHCS) to support quality improvement in small practices serving high volumes of low-income and racially and ethnically diverse patients with diabetes. Its goal was to test the ability of state Medicaid agencies, health plans, primary care case management programs (PCCM), and other Medicaid partners to assist small practices in improving diabetes care by providing data, health information technology (HIT), care management resources, quality improvement training, and capital.

State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania participated in the initiative from October 2008 to December 2011, including six to 12 small primary care practices in each state. To identify eligible practices, the states used common criteria related to the number of: (1) providers in the practices; (2) patients diagnosed with diabetes; (3) patients covered by Medicaid or uninsured; and (4) patients from racial/ethnic minority groups (Exhibit 1).

Working within their existing Medicaid delivery systems – PCCM models in North Carolina and Oklahoma, and health plan-based models in Michigan and Pennsylvania – each state developed their own practice-based intervention including the following elements:

- Data on diabetic patients and the services received;
- HIT, such as support to purchase, install, and populate a registry to identify and track diabetic patients;

- Care management resources, such as a practice-based or “embedded” nurse care manager;
- Practice facilitation or coaching on practice workflow, quality measurement, medical home elements, financial management, etc.;
- A learning collaborative for participating practices; and
- Financial support via up-front grants, milestone-based payments, and/or per member per month payments.

These practice-level interventions were provided via a practice facilitator/coach, a care/case manager, or both. Practice facilitators or coaches helped practices improve their workflows, business models, patient outreach methods, registry selection and maintenance, chronic illness management, and patient education. Care/case managers were typically part-time staff members who were responsible

Exhibit 1: Reducing Disparities at the Practice Site Pilot Characteristics

SITE	MICHIGAN	NORTH CAROLINA	OKLAHOMA	PENNSYLVANIA
PRACTICES	6	12	10	8
POPULATION	860 Medicaid patients with diabetes (out of 14,000 Medicaid beneficiaries served by the practices; 93% racially/ethnically diverse)	614 Medicaid patients with diabetes (out of 10,000 Medicaid beneficiaries served by the practices; 43% racially/ethnically diverse)	507 Medicaid patients with diabetes (out of 17,000 Medicaid beneficiaries served by the practices; 50% racially/ethnically diverse)	800 Medicaid patients with diabetes (out of 12,000 Medicaid beneficiaries served by the practices; 95% racially/ethnically diverse)
DELIVERY MODEL	MCO	PCCM	PCCM	MCO
PRACTICE FACILITATION VENDOR	Prism	IPIP	IFMC	NEVA
PRACTICE TRANSFORMATION STRATEGY	“Practice buddy” quality improvement staff person employed by health plans	Practice facilitators employed by a vendor	Practice facilitators employed by a vendor	Nurse serving as both care manager and practice facilitator
PATIENT REGISTRY	Cielo MedSolutions or Wellcentive	Reach My Doctor	CareMeasures	Reach My Doctor
FINANCIAL INCENTIVES	Practices received \$1 PMPM; half upfront and half at the conclusion of the project.	Practices received up to \$5,000 in first pilot year; also free CME credits for one physician.	Practices received up to \$4,000 per year for participation, reporting registry data, and active use of process improvement strategies.	Practices received pay-for-performance incentives for reporting and improving performance on diabetes care measures through an existing state initiative.

for entering data into the registry, identifying patients needing additional tests or services, conducting patient assessments and education, and following up with patients to get them into the office for their appointments.

Oklahoma and North Carolina partnered with external vendors to provide practice facilitation. In Oklahoma, this was the Iowa Foundation for Medical Care (IFMC),⁷ while North Carolina used Improving Performance in Practice (IPIP)⁸ (Exhibit 1). Both vendors had extensive experience in practice transformation and HIT implementation. The other two states, Michigan and Pennsylvania, partnered with their health plans to support the participating practices. In Michigan, each health plan deployed a “practice buddy” – a quality improvement health plan staff member – to work with practices on behalf of all the other Medicaid health plans. In Pennsylvania, the state contracted with a nurse care manager who was embedded part-time within the practices to provide care management and quality improvement assistance, again on behalf of all three Medicaid health plans. The state also asked its external quality review organization (EQRO) to collect and aggregate member- and provider-level data from the plans to identify the target practices. The nurse care manager worked with the health plans to identify additional care management resources at the plan or in the community.⁹

Implementation of HIT, whether a registry or an EHR, was a primary aspect of the practice support in all four states. The RDPS practices needed an electronic process to facilitate collection and analysis of patient information in order to identify and track diabetics and disparities, for example. In Pennsylvania, Oklahoma, and North Carolina, the state teams offered practices a pre-selected registry application, which eliminated the need to explore the numerous registry options available. Practice facilitators in Oklahoma and North Carolina had experience working with the registry application, which made implementation smoother. In Michigan, the state team allowed practices to choose from a subset of applications/vendors. As a result, the practice buddies had to become familiar with different systems, which made implementation more challenging.

Initiative Evaluation

Both an outcomes and process evaluation were conducted to assess RDPS. The outcomes analysis, which examined claims, encounter, enrollment, disease registry, and lab data from three of the participating states, did not find evidence of impacts on quality of care or health care service use in the three states.¹⁰ While the lack of evidence of impact is disappointing, it may not be surprising. The small number of practices and patients, particularly in Oklahoma and North Carolina, may have hampered the evaluator’s ability to

detect statistically significant differences before and after the initiative. Furthermore, in some states the practice interventions did not occur until the second year, thus the intervention may not have been in place long enough to have a positive impact.

The process analysis, which included site visits, interviews, and document review, focused on implementation of RDPS in four states at multiple levels: state, plan, provider, and to a limited extent, patient. The evaluators interviewed approximately 50 individuals across the four sites, including representatives from state Medicaid agencies, medical directors from health plans, analysts involved with the projects, practice facilitators and care managers, quality improvement experts, and health care providers.

The remainder of this brief presents the key findings from the process analysis and describes how lessons from the RDPS initiative can inform efforts to sustain small primary care practices and improve the care they provide.

Key Themes for Improving Care at the Practice Site

The process analysis revealed several key lessons from the RDPS sites that can help additional states in developing practice-site improvement efforts:

1. **Although selected using common criteria, the RDPS practices were quite heterogeneous, with practice leadership and culture being the most important – and subjective – factors for success.** The engagement of practice leadership, awareness of and interest in quality improvement, and bandwidth to engage in the initiative varied significantly. Because of limited resources to invest in the RDPS practices, some states prioritized practices that appeared to be “amenable to the project,” “willing to change,” and “good players.” Such practices embraced the opportunity to provide better outcomes for their patients and were motivated by the opportunity to connect to available technology, such as registries or EHRs. That said, states were also concerned about “leaving behind” eligible practices that were not motivated since they were not likely to have other opportunities to improve patient care delivery.
2. **Maintaining practice engagement throughout the initiative was a major challenge.** Even if practices stated their willingness and commitment up front, ongoing engagement in the project varied widely. However, the general perception of the state teams was that even practices that participated at a very minimal level made incrementally positive change.

3. **Practices needed both practice facilitation and care management support.** As described earlier, the state teams provided practices with practice facilitators, care/case managers, or both. There was nearly universal agreement that practices needed both the quality improvement expertise of the practice facilitator and the day-to-day patient management skills of the care manager. However, the assessment confirmed that the same person should not do both jobs because they require different skill sets.
4. **Practice facilitation was most effectively provided by an entity external to the practice with the relevant experience and skill set.** Two states, North Carolina and Oklahoma, contracted with vendors to work with the RDPS practices. These vendors had already been working with non-RDPS practices on improving quality, so they had standardized processes, materials, and interventions. As a result, they were able to “hit the ground running” and engage with the physician practices – performing practice assessments and offering coaching to improve administrative and care processes within the practices. In contrast, in Pennsylvania and Michigan, the practice buddies and the nurse care manager had little to no experience with practice facilitation or care management at the point of care, and had to “start from scratch” for the most part, with developing processes, tools, and templates for the project.
5. **Receptivity to care management/coordination supports was mixed, and the belief that the practices would ultimately “take over” and provide care management activities proved unrealistic.** Many practices appreciated the work of the nurse care manager, but conceptualized the role as a “staff extender,” not as a permanent practice employee. Some practices were resistant to a care manager as they were already coordinating patient care and did not want an additional in-house care coordinator to impact the practice’s workflow. At the conclusion of the RDPS initiative, finding the most effective way to help small practices manage the care of their complex patients remained one of the more elusive “nuts to crack.”
6. **Investment in the RDPS practices needed to be ongoing.** The state teams found that their initial expectations about practice facilitation were incorrect – they assumed the work with the practices would be a finite task. However, as the initiative evolved, the state teams realized that “graduating” practices would be unrealistic. Furthermore, the timeframe set for the practice to transform was too short. The state teams and facilitators needed to be much more flexible and “hands-on,” working with the practices on an ongoing basis because the practices did not have the anticipated capacity for change. Nor was progress an uninterrupted or smooth process.
7. **Financial incentives were not the primary motivator or driver of change.** Although financial incentives to practices were viewed as important, it was unclear what role such payments played in getting practices to remain engaged. While some providers felt that incentive payments provided needed operating income, other respondents were not sure how much of a difference this extra money played. Factors such as practice leadership and having a clinical champion appeared to have a greater impact on a practice’s willingness to change than incentive or milestone-based payments. Respondents concluded that although incentives may not drive change, they offered a mechanism to assist practices in meaningful ways and encourage their participation.
8. **HIT was too overwhelming for most practices to implement to its fullest capacity.** RDPS required practices to use HIT to facilitate population management. However, delays in the selection of patient registry software, installation, and training reduced the time available to integrate patient registries into practice workflows and show a positive impact on patient outcomes. Other limiting factors included lack of access to or experience with information technology as well as lack of time and resources to convert from paper to computer records or for registry maintenance. Some RDPS practices that were affiliated with a physician organization or health system struggled with a lack of control over data flow from practice management systems and the inability to automatically download data into the registry. Because of the many challenges of implementing HIT, the majority of practices were not able to use the registries to their fullest capacity. Many practices were initially attracted to participate in the initiative because of the promise of HIT; however, implementation of a registry was arduous for practices, and it was possible only with significant ongoing support from the care managers or practice facilitators.
9. **While health plans embraced the opportunity to collaborate on practice-based quality improvement, the reality of day-to-day involvement at the point of care was more challenging.** The plans enthusiastically provided substantial financial incentives to the practices, hands-on support for the registries and performance measurement, coaching on medical home

transformation, and other supports. The direct practice facilitation – a new role for the Michigan practice buddies – demanded much more staff time than anticipated. Furthermore, the capacity for the practices to fully understand and apply these new lessons was much more limited than anticipated. In Pennsylvania, the plans struggled to find a meaningful role in the initiative since much of the “heavy lifting” of practice facilitation and care management was performed by an external nurse care manager.

10. **Improving quality and reducing disparities in the practices will likely be more sustainable in PCCM models.** RDPS examined whether states that involved health plans in practice transformation could be as successful as states with a PCCM model. While both models experienced some success in the project, the process evaluation showed that the PCCM model may be better able to sustain the elements of the RDPS intervention beyond the funding period of the grant. This is most likely because the practice facilitation and care management interventions were more “institutionalized” in the PCCM programs. While the health plans were positive about the RDPS initiative and the opportunity to collaborate with each other, at the end of the initiative, they looked to the state to sustain the ongoing work with the practices.

Implications for Medicaid Stakeholders

Small practices serving vulnerable low-income populations are critical partners for ensuring the success of health care reform. As such, it will be important for Medicaid, PCCM programs, and health plans to better understand these practices and their needs. In addition to specific lessons from the RDPS state pilots outlined earlier, the four-state initiative offers broad lessons about improving the quality of care provided by small, under-resourced primary care practices:

- Medicaid agencies can use claims and race/ethnicity/language (REL) data to identify small practices with larger Medicaid and racially diverse patient panels. By targeting RDPS to this specific provider subpopulation, the participating states could more effectively use limited resources on practices that could yield a “bigger bang for the buck,” i.e., quality would be improved for a large number of Medicaid patients. Larger practices, such as federally-qualified health centers or clinics, were not targeted even although they serve a much larger number of Medicaid patients because these providers are typically more likely to have access to and/or be involved in quality improvement efforts.
- Medicaid has the ability to bring greater attention to small, high-volume Medicaid providers and the critical role they play in the health care delivery system. By partnering with Medicaid health plans, other payers, regional quality coalitions, universities and other entities, states can ensure that quality improvement resources reach small, high-volume, under-resourced practices. Investments in small practices can include: (1) technical assistance and resources to transform into medical homes; (2) support for quality improvement initiatives focused on strengthening these practices; (3) learning collaboratives to build the quality improvement skill set for practices and their staff; (4) HIT including registries and data analytic support; and (5) care management teams and support.
- Medicaid can “institutionalize” efforts so that investments in primary care are ongoing. States and health plans can:
 - Provide practices with data analytics and quality information on their chronically ill patients;
 - Include a focus on reducing disparities in the state’s annual quality strategy and EQRO contracts;
 - Design quality improvement initiatives and training curricula that include small, high-volume but under-resourced practices; and
 - Insert language in provider contracts regarding the state’s expectations of practice participation in transformation, among other strategies.
- Medicaid can increase care management resources for small, high-volume practices, particularly focused on patients with complex needs. Medicaid health plans could deploy care managers directly to help practices manage complex patient care more effectively. States could implement health homes – Section 2703 of the Affordable Care Act – to allow Medicaid to reimburse for complex care management and care coordination services. The health home teams could partner with small practices to help manage care transitions, link patients to critical social services and supports, and better integrate physical and behavioral health, for example.
- Medicaid should consider ways to strengthen linkages between small under-resourced practices and other providers, including specialists, behavioral health providers, and hospitals. States and policymakers should think about these practices in relation to the larger

health care community. Quality does not and cannot stop at the “four walls of the practice,” particularly for high-need Medicaid populations that often require more social services and supports, or behavioral health services, than the commercial or Medicare populations.

Conclusion

The nation’s health care delivery system is undergoing unprecedented transformation. Even though hospitals and health systems are purchasing primary care practices at an accelerating rate, small practices are likely to remain an important piece of the health care delivery system for years to come.

State Medicaid agencies have many levers they can pull to improve quality throughout the delivery system. They can implement complex care management, manage health care services through health plans, partner with other payers, develop a quality strategy, and implement policies that reimburse for value rather than volume. Medicaid agencies are well positioned to develop policies supporting and strengthening primary care and its providers. In doing so, Medicaid agencies can partner with health plans and other payers to provide ongoing supports and technical assistance to practices, and ensure that small practices are not left behind.

About 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 access and quality for low-income Americans. 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. For more information, visit www.chcs.org.

This brief is a product of CHCS’ *Reducing Disparities at the Practice Site* program, made possible through the Robert Wood Johnson Foundation. This three-year project in Oklahoma, Michigan, North Carolina, and Pennsylvania tested the leverage that Medicaid agencies, health plans, primary care case management programs, and other community-based organizations have for improving chronic care at small practices serving racially and ethnically diverse beneficiaries. For more information, visit www.chcs.org.

Endnotes

¹ Moon J, Weiser R, Highsmith N, Somers SA. “The Relationship of Practice Size and Quality of Care in Medicaid.” Center for Health Care Strategies, July 2009. Available at: http://www.chcs.org/usr_doc/Relationship_between_Practice_Size_and_Quality.pdf.

² Ibid.

³ Pham H, Schrag D, Hargraves JL, Bach P. “Delivery of Preventive Services to Older Adults by Primary Care Physicians.” *Journal of the American Medical Association*, July 27, 2005; 294(4): 473-481.

⁴ Ketcham J, Baker L, Maclsaac D. “Physician Practice Size and Variations in Treatments and Outcomes: Evidence From Medicare Patients With AMI” *Health Affairs*, January 2007; 26(1): 195-205.

⁵ Audet A, Doty M, Shamasdin J, Schoenbaum S. “Measure, Learn, and Improve: Physicians’ Involvement in Quality Improvement.” *Health Affairs*, May 2005; 24(3): 843-853.

⁶ Congressional Budget Office and Joint Committee on Taxation. *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*. July 2012.

⁷ In 2011 IFMC (Iowa Foundation for Medical Care) became Telligent. For more information see: <http://www.telligent.org>.

⁸ For more information, see: <http://www.ipipprogram.org>.

⁹ For more information about how the initiative was structured, please visit <http://www.chcs.org>.

¹⁰ Michigan Medicaid elected not to participate in the quantitative evaluation for RDPS.