

## Project Profile - *Reducing Disparities at the Practice Site: Detroit, Michigan*

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### Initiative Overview

The Center for Health Care Strategies (CHCS) developed the *Reducing Disparities at the Practice Site* initiative 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. These stakeholders can play a critical role in facilitating and sustaining improvements in care by providing practice sites with data, technology, care management resources, quality improvement training, and capital.

Through the initiative, state-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania are building the quality infrastructure of 36 high-volume primary care practices that together serve 53,000 Medicaid patients. Recognizing that small primary care practices have limited resources to engage in quality improvement activities, *Reducing Disparities at the Practice Site* is 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.

Each state team is implementing a unique model of leveraged practice improvement support for small, high-opportunity Medicaid practices. This document describes the approach underway in the state of Michigan. For profiles of the other state models, please visit [www.chcs.org](http://www.chcs.org).

### Detroit's Model

#### Background

Michigan Medicaid has approximately 1.5 million beneficiaries, 60 percent of whom are enrolled in risk-based managed care, provided by 14 health plans. Together, these plans serve all 83 counties in the state.

Through its 2008 *Practice Size Exploratory Project*, CHCS identified a number of practices in Southeast Michigan with notable disparities in access and clinical quality measures (primarily in the African-American population).<sup>1</sup> Six identified practices affiliated with the six Medicaid health plans serving Southeast Michigan (Detroit region) were invited to participate in the *Reducing Disparities at the Practice Site* initiative.

Michigan's engagement in several major primary care practice improvement efforts served as an opportune context for launching its program. These include its *Primary Care Consortium* (PCC), a unique collaboration to improve the delivery of prevention and disease management services in primary care settings throughout the state; and its involvement in *Improving Performance in Practice* (IPIP), a national quality initiative to assist physicians in improving care in the office practice setting. Two Michigan communities are also among those participating in *Aligning Forces for Quality*, the Robert Wood Johnson Foundation's program to assist communities in improving the quality of health care for patients with chronic conditions.

<sup>1</sup> As part of CHCS' *Practice Size Exploratory Project*, Michigan was one of five regions that analyzed health plan data to explore whether practice size may be related to variations in access and clinical quality measures. For a study overview, visit [www.chcs.org](http://www.chcs.org).

## Program Goals and Components

The goal of Michigan's *Reducing Disparities at the Practice Site* initiative is to help 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 close to 14,000 Medicaid patients – 93 percent of whom are from racial/ethnic minority groups (see Table 1).

Number of participating practices	6
Number of Medicaid patients served	13,744
Percentage of Medicaid patients who are racially/ethnically diverse	93%
Number of Medicaid patients with diabetes	860
Number of racially/ethnically diverse Medicaid patients with diabetes	774
Financial incentive strategy for practices	Plans contribute equally to the pool. Practices receive dollars based on their number of Medicaid patients.

Physician Practice Connections — Patient-Centered Medical Home (PPC-PCMH) has been embraced widely as a model that emphasizes the systematic use of patient-centered, coordinated care management processes and aims to strengthen the patient-physician relationship by replacing episodic care with coordinated care. There are nine standards that comprise the three levels of the PCMH, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions, and performance reporting and improvement.<sup>2</sup>

To support the six practices, the Michigan team is: (1) providing each practice with a per member per month (PMPM) financial payment for participation; (2) funding, implementing, and populating a patient registry in each practice; and (3) providing each practice with a quality improvement expert to help navigate the PPC-PCMH certification process. Each program component is described further below.

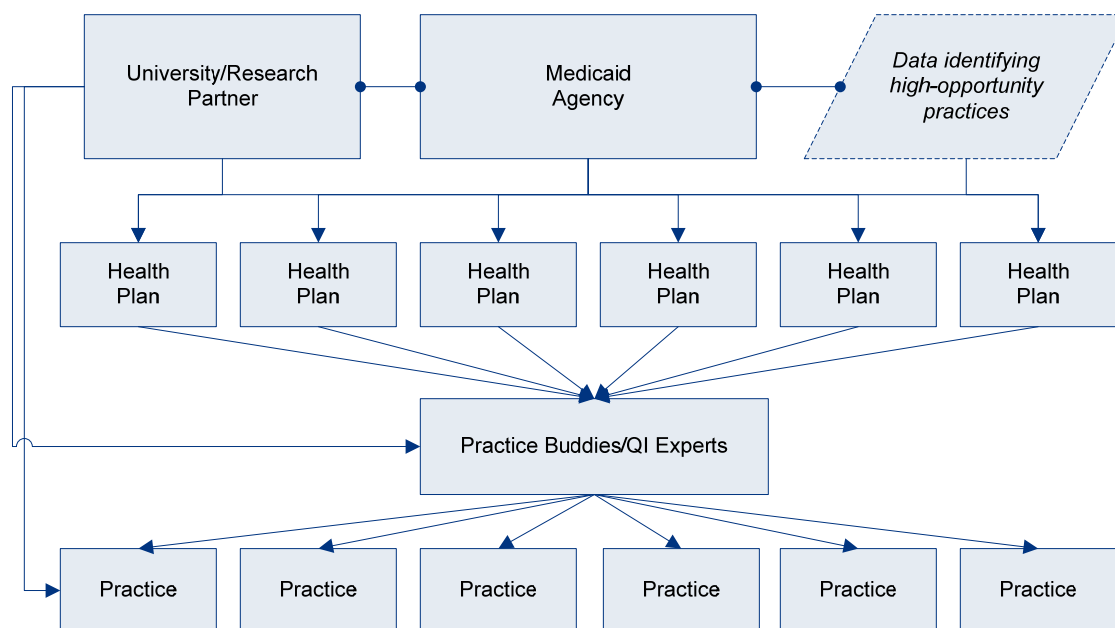
### Team Structure

Michigan's team (see Figure 1) is 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 are six Medicaid plans that contract with the practices: Health Plan of Michigan, Molina Healthcare Michigan, Great Lakes Health Plan, MidWest Health Plan, OmniCare, Total Health Care; the Greater Detroit Area Health Council (GDHAC); the University of Michigan; and local public health organizations.

Each health plan is providing a dedicated quality improvement expert — a so-called “practice buddy” — to work with the practices. Each practice buddy outreaches to and engages an individual practice, conducts a practice assessment, and provides support, as needed, to address the PPC-PCMH elements. While employed by a specific plan, each practice buddy represents all six of the plans in his/her work.

<sup>2</sup> For more information on PPC-PCMH, visit [www.ncqa.org](http://www.ncqa.org).

**Figure 1: Team Structure for Michigan’s Project**



### *Engagement and Assessment of High-Opportunity Practices*

Practices eligible for the program have four or fewer primary care physicians, and at least a 60 percent racially and ethnically diverse patient population. Each of the participating practices contracts with at least four of the six plans. The practice buddies approached eligible practices about participating in the initiative; those interested signed a memorandum of understanding to join.

The Michigan team adopted a three-part practice assessment approach, performed by the practice buddy, incorporating: 1) the Assessment of Chronic Illness Care (ACIC) tool developed by the MacColl Institute for Healthcare Innovation; 2) NCQA’s PCMH self-assessment tool; and 3) questions assessing the culture of the practice, including different sets of questions for the clinical staff and the administrative staff. Results from the assessment tools, including an initial rough estimate of the practice’s PCMH level, are calculated by the practice buddy and shared with the practice.

### *Financial Support*

The plans are all supporting the practices with financial incentives of \$1PMPM for participation. Half of the payment is provided initially, and half at the conclusion of the project. While the total amount of the financial incentive varies by the size of the practice’s panel, the average payment per practice is approximately \$13,000.

### *Registries: Identifying and Tracking Diabetic Patients*

The Michigan team explored numerous registry products, focusing on the tools most commonly used by providers in the Detroit area. Based on that research and subsequent demonstrations with registry vendors, the team identified two products to purchase collectively for the targeted practices: Cielo MedSolutions<sup>3</sup> and Wellcentive<sup>4</sup>. Two critical features of these products were the ability to

<sup>3</sup> For more information, visit [www.cielomedolutions.com](http://www.cielomedolutions.com).

<sup>4</sup> For more information, visit [www.wellcentive.com](http://www.wellcentive.com).

accommodate data and measures for multiple chronic conditions, and to serve multiple populations, regardless of payer source.

Participating practices select one of the two products; if a practice already has a registry or electronic health record in place, the practice buddy will work with the practice to use existing functionalities to measure diabetes performance for the target patient population.

Participating practices receive information on and an initial demonstration of the registry products by the vendors. Each practice will also receive 40 hours of individual training by the vendor. To provide ongoing support for registry implementation, the practice buddies will be deployed to help implement, initially populate, and extract and analyze data from the tool.

The Institute for Health Care Studies is providing staff to perform an initial “data dump” of demographic and patient data from 36 medical charts into each practice’s registry. This up-front support is critical to getting the practices “off on the right foot.”

### ***Practice Redesign: Providing Quality Improvement Supports***

Each practice and its buddy will be working together in Year Two of the initiative to develop a work plan that reflects the practice’s priorities and allows it to be prepared to achieve at least Level 1 PCMH certification.

## **Next Steps**

In the first year of the national initiative (October 2008 to September 2009), the four state teams, including Michigan, have made tremendous strides, from designing their programs, to engaging 36 practices, to deploying practice facilitators and assessing practices' needs, priorities, and opportunities. In Year Two, the state teams will continue to strengthen the practice infrastructure, enhance care management supports, and explore strategies to engage patients.

## **About CHCS**

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. We work with state and federal agencies, health plans, providers, and consumers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs.