Project Profile - *Reducing Disparities at the Practice Site*: North Carolina

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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 North Carolina. For profiles of the other state models, please visit **www.chcs.org**.

North Carolina's Model

Background

The Community Care of North Carolina (CCNC) program includes 14 regional community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. Through these networks, the program establishes the local systems needed to achieve long-term quality, cost, access, and utilization objectives to improve care for Medicaid beneficiaries.

The North Carolina Office of Rural Health and Community Care administers CCNC, and is funded by the Division of Medical Assistance (the state's Medicaid agency) and the North Carolina Foundation for Advanced Health Programs, Inc.

CCNC's 14 networks include more than 4,000 physicians serving more than 950,000 of the state's 1.4 million Medicaid beneficiaries. Extending into all 100 North Carolina counties, the collaborative is structured as an enhanced fee-for-service model, providing participating primary care providers with $2.50 per member/per month (PMPM) for key access and disease and population management activities. Each local CCNC network receives $3 PMPM to support case and disease management activities and staff. An additional $2.50 PMPM is paid to providers and networks for the management of the aged, blind and disabled population. The underlying Medicaid reimbursement for physicians is relatively high —95 percent of Medicare in 2008 — compared to other state Medicaid programs.[1]

[1] J.M. Verdier, V. Byrd, and C. Stone. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States.* Center for Health Care Strategies, September 2009. Available at **www.chcs.org**.

CCNC's delivery structure and its engagement in disparities and quality improvement initiatives provided a strong foundation for launching its *Reducing Disparities at the Practice Site* initiative.

Program Goals and Components

The goal of North Carolina's *Reducing Disparities at the Practice Site* initiative is to improve chronic care delivery in small primary care practices serving high volumes of Medicaid patients across the state. As of October 2009, 12 physician practices serving more than 10,000 Medicaid patients — almost half of whom are from racial/ethnic minority groups — were participating (see Table 1).

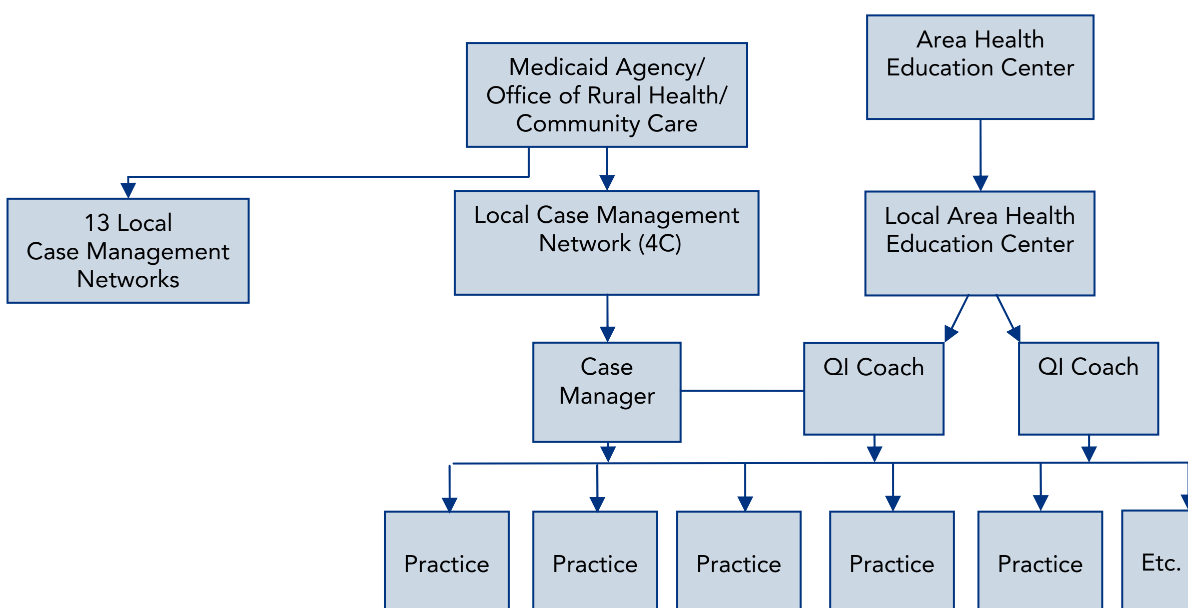
Table 1. North Carolina's Program: A Snapshot (October 2009)	
Number of participating practices	12
Number of Medicaid patients served	10,190
Percentage of Medicaid patients who are racially/ethnically diverse	43%
Number of Medicaid patients with diabetes	614
Number of racially/ethnically diverse Medicaid beneficiaries with diabetes	359
Financial incentive strategy for practices	Practices will receive scholarships for start-up costs, registry implementation and outcome improvements; and free CME credit programs focused on improving diabetes care.

To support participating practices, the state team is: (1) offering them financial incentives around registry implementation; (2) working directly with practices to help establish and effectively utilize a patient registry; and 3) supporting performance improvement efforts to improve diabetes health outcomes for the racially and ethnically diverse population.

Team Structure

North Carolina's team is led collaboratively by the state (Medicaid agency, Office of Rural Health and Community Care) and the local CCNC case management network (Carolina Collaborative Community Care or "4C"). The state and 4C are also partnering with Area Health Education Centers (AHEC) that sponsor *Improving Performance in Practice* (*IPIP*), a national ambulatory quality improvement initiative to deliver support around registry implementation and practice redesign efforts. This project is also supported by existing quality improvement efforts in the 4C network, including a diabetes initiative that targets all network practices. Two *IPIP* quality improvement coaches (QICs) and a CCNC nurse case manager are engaging practices and supporting practice transformation in this initiative (see Figure 1).

Figure 1: Team Structure for North Carolina's Project



Engagement and Assessment of High-Opportunity Practices

The 4C network is located in Cumberland County, an area with a high minority population and approximately 75 small- and medium-sized practices. Medicaid patients are more evenly diffused across small practices in the 4C network, rather than concentrated in a few. Practices eligible for the initiative had four or fewer physicians, at least 200 Medicaid patients, a Medicaid patient panel that was at least 30% racially and ethnically diverse, and 50 or more patients with diabetes.

To initiate recruitment, 4C's medical director and executive director approached target practices, describing the RDPS project and support 4C could provide and gauging each practice's level of interest. Through these efforts, they recruited 12 practices to participate. The local network and clinical leadership has proven key to the success of physician engagement and buy-in.

The North Carolina team is using materials developed by IPIP to assess the baseline status of participating practices. Information regarding general practice features and the delivery of chronic care are collected from an *IPIP*-developed initiative application and through an on-site interview conducted by the program case manager and *IPIP* QICs. The interview includes direct observation of practice functioning. Findings are shared with the practice and used to develop a tailored work plan addressing the practice's priorities and opportunities for improvement.

Financial Support

Practices participating in *Reducing Disparities at the Practice Site* are eligible for scholarships to support their efforts in implementing a registry and activities to improve outcomes in diabetes care. While measures for diabetes performance incentives are in development, the maximum award per practice across these activities in the first year will be $5,000.

North Carolina is also offering one provider the opportunity to serve as "physician champion" – helping promote practice redesign to peer practices and providers. Physicians will also be provided opportunities for free CME credits focused on improving health outcomes for the diabetic population, i.e., cultural competency, motivational interviewing, or behavioral health integration.

Registries: Identifying and Tracking Diabetic Patients

A primary impetus for partnering with *IPIP* was its strong expertise around registry implementation and use, and experience utilizing the *Reach My Doctor* (RMD) web-based patient registry.[2] RMD is a point-of-care decision-support tool that helps organize staff workflow and enables optimal, efficient care delivery by the physician. It includes HIPAA-compliant e-mail communication to facilitate coordination of care, as well as a patient portal to foster patient engagement.

RMD functions include automatic e-mail reminders to patients when they are due for care; access to patient contact information to reach patients who are not using the patient portal; and facilitation of appointment requests, pharmacy refills, and responses to billing questions. In addition, RMD supports coordination across the practice team and with external providers.

Practice Redesign: Providing Quality Improvement Supports

4C and *IPIP* are working collaboratively to provide practices with on-site technical assistance on Chronic Care Model[3] adoption and process improvement. The local network has been implementing a chronic care initiative for the past three years. This includes working with practices to provide transitional support, team-based care led by the PCP, targeted care management, and medication reconciliation for populations with more complex needs. 4C is leveraging *IPIP*'s technical expertise around registry functionality and use – an aspect critical for practices to monitor, provide, and demonstrate the quality of patient care.

In addition, 4C's network case managers continue to provide support to each of the participating practices around the care management of their diabetes population.

Next Steps

In the first year of the national initiative (October 2008 to September 2009), the four state teams, including North Carolina, 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.

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[2] *ReachMyDoctor* is a service of RMD Networks, Inc. For more information, visit **www.rmdnetworks.com**.
[3] Developed by the MscColl Institute for Healthcare Innovation; see www.improvingchroniccare.org.