Project Profile - *Reducing Disparities at the Practice Site*: Oklahoma

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

Oklahoma's Model

Background

The Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, has approximately 650,000 beneficiaries. Since January 2009, all beneficiaries are served in either a patient-centered medical home model (SoonerCare Choice) or in a traditional fee-for-service program. OHCA does not contract with health plans.

OHCA's comprehensive and innovative Health Management Program (HMP) was designed by OHCA and is administered by the Iowa Foundation for Medical Care (IFMC), an organization focused on improving the quality, delivery, and cost of health care services.

The HMP is a "dual-armed" program: one arm is focused on high-risk SoonerCare members with chronic conditions, and the other on care delivery system redesign at the practice site. OHCA relies on MEDai predictive modeling software to identify members and providers eligible for these services.

OHCA designed its *Reducing Disparities at the Practice Site* initiative within the HMP framework. While HMP is available to practices of all sizes, this initiative focuses on small practices with high volumes of racially and ethnically diverse Medicaid patients.

Program Goals and Components

The goal of Oklahoma's *Reducing Disparities at the Practice Site* initiative is to improve chronic care delivery in 10 small primary care practices serving high volumes of Medicaid beneficiaries across the state (see Table 1). As of October 2009, 10 practices, comprised of physicians, nurse

practitioners and physician assistants, serving almost 17,000 Medicaid patients — about half of whom are from racial/ethnic minority groups — were participating (see Table 1).

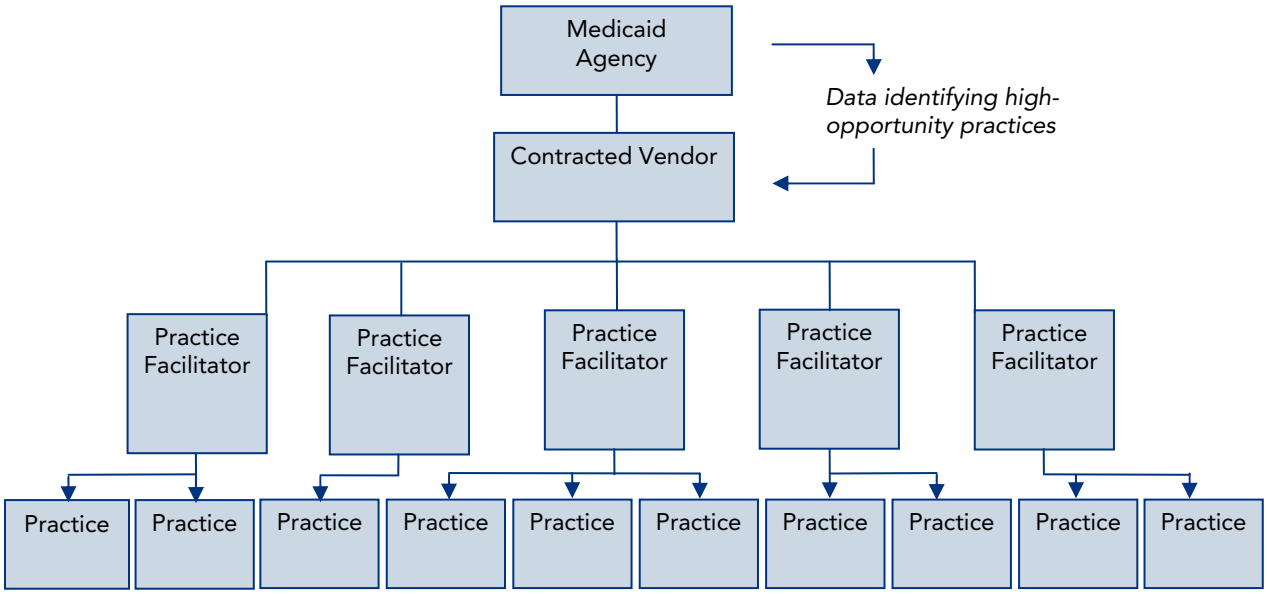
Table 1. Oklahoma's Program: A Snapshot (October 2009)	
Number of participating practices	10
Number of Medicaid patients served	16,893
Percentage of Medicaid patients who are racially/ethnically diverse	48%
Number of Medicaid patients with diabetes	507
Number of racially/ethnically diverse Medicaid patients with diabetes	285
Financial incentive strategy for practices	Each practice can receive up to $4,000 per year for participation, reporting registry data, and active use of process improvement strategies.

To support these practices, the Oklahoma team is: (1) providing each practice with financial incentives for participation; (2) funding, implementing, and initially populating a patient registry, CareMeasures, in each practice; and (3) providing each practice with a dedicated practice facilitator. Each program component is described further below.

Team Structure

OHCA provides infrastructure support, including identification of target practices and other data analysis functions. IFMC employs, trains and deploys five nurses who serve as practice facilitators to the 10 participating practices (see Figure 1).

Figure 1. Team Structure for Oklahoma's Project



Engagement and Assessment of High-Opportunity Practices

Practices eligible for the Oklahoma initiative have four or fewer physicians, and at least 500 Medicaid patients. Using MEDai, OHCA identified eligible practices based on forecasted risk, practice size, and panel size. A representative from OHCA and IFMC approached each identified practice to explain the intent of the program, discuss incentives, and encourage participation.

An IFMC practice facilitator is deployed to each practice upon its commitment to participate in the program. The facilitator gathers basic information about the practice including available technology, staff and staff roles, and current goals and priorities. Several different tools are used in the assessments, including the Assessment of Chronic Illness Care tool developed by the MacColl Institute for Healthcare Innovation, and a clinical practice self-evaluation. Results from the assessments are shared with each practice.

The practice facilitators play many roles. They hold weekly meetings to facilitate staff communication and keep the team updated on goals, progress, and re-evaluation of performance; perform practice assessments; conduct staff interviews; shadow staff throughout their job responsibilities; and perform chart abstractions and process mapping. Based on this work, the facilitators provide practices with feedback, help identify areas of improvement related to patient care, and assist in developing a list of redesign priorities and an action plan

Financial Support

Each practice receives a financial incentive of $500 for engaging in practice facilitation activities. They also are eligible to receive quarterly pay-for-reporting awards if they report data on all Medicaid members with diabetes; the award amount increases as the number of members entered in their registry increases. Financial incentives are also available to practices demonstrating improvements in diabetes care performance in CareMeasures.

Registries: Identifying and Tracking Diabetic Patients

Practices utilize the CareMeasures web-based patient registry designed by IFMC to track patients with diabetes. CareMeasures captures data and calculates performance for several chronic conditions; however, practices participating in *Reducing Disparities at the Practice Site* are focusing on those specific to diabetes. The practice facilitator initially populates Care Measures with data on diabetic patients and then teaches staff how to enter, update, and report data.

CareMeasures allows an entire practice to stay up-to-date on the care of each patient and his or her disease status. Through a patient summary page printed in advance of each visit, practices can proactively identify diabetic patients and their care needs, facilitating performance of services required to complete the quality measures. This empowers and better-equips staff to manage chronic care proactively — identifying gaps in care and assisting the clinician in closing those gaps.

Through use of CareMeasures, practice staff better understand ambulatory quality measures and incorporate them into their daily practice. They run routine reports of quality measures, monitor performance, and make adjustments as needed.

Practice Redesign: Providing Quality Improvement Supports

The three primary roles of the practice facilitator are to: (1) help a practice improve the care of its chronically ill patients; (2) establish processes that apply evidence-based guidelines and quality measures to patient care; and (3) teach quality improvement processes and help the practices carry these out

independently. By teaching team-based care, CareMeasures, quality improvement tools, and population management, the facilitators help to redesign participating practices.

Next Steps

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

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.