CHCS Center for Health Care Strategies, Inc.

Project Profile - *Reducing Disparities at the Practice Site*: Philadelphia, Pennsylvania

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

Philadelphia's Model

Background

Pennsylvania's Medicaid program is operated by the Department of Public Welfare's Office of Medical Assistance Programs (OMAP). Care is provided through two delivery systems: managed care organizations (MCOs) and an enhanced primary care case management (EPCCM) program. The delivery system varies geographically, with the MCOs operating regionally around urban areas like Philadelphia and Pittsburgh.

Pennsylvania's ongoing commitment to quality improvement activities created a strong foundation for its participation in the *Reducing Disparities at the Practice Site* initiative. Such efforts include the Pennsylvania Chronic Care Collaborative, a multi-payer, practice-based initiative to improve chronic disease care; ongoing analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data to identify health disparities; and pay-for-performance programs for Medicaid MCOs and physicians.

Through its collection of HEDIS data, the state found a high prevalence of diabetes in racial/ethnic minority groups throughout the state, with some of the greatest disparities in care in Philadelphia. These disparities were consistent with data from CHCS' 2008 *Practice Size Exploratory Project*,[1] which found that small physician practices play a critical role in the delivery of care to Medicaid beneficiaries in select regions. Accordingly, OMAP targeted Philadelphia as an opportune area for improving quality and reducing disparities.

[1] Southwest Pennsylvania was one of five regions in CHCS' *Practice Size Exploratory Project* that analyzed heath plan data to explore whether practice size may be related to variations in access and clinical quality. For a study overview, visit **www.chcs.org**.

Program Goals and Components

The goal of Pennsylvania's *Reducing Disparities at the Practice Site* initiative is to improve the quality of chronic care among adult Medicaid patients with diabetes, as measured by improvements in HEDIS diabetes measures. As of October 2009, eight physician practices serving more than 12,000 Medicaid patients – 95% of whom are from racial/ethnic minority groups – were participating (see Table 1).

Table 1. Pennsylvania's Program: A Snapshot (October 2009)

Number of participating practices	8
Number of Medicaid patients served	12,177*
Percentage of Medicaid patients who are racially/ethnically diverse	About 95%**
Number of Medicaid patients with diabetes	776*
Number of racially/ethnically diverse Medicaid patients with diabetes	758*
Financial incentive strategy for practices	Pay-for-participation and -performance programs

* Figure reflects seven of the eight participating practices.
** Based on the HEDIS AAP measure of 2007.

To support the eight practices in achieving the program goal, the Pennsylvania team is providing them with: (1) financial incentives for improved diabetes-related HEDIS measures; (2) access to and support for using the *Reach* My Doctor (RMD)[2] online patient registry; and (3) a shared nurse care manager based within the practices to support improvements in care processes for patients with diabetes. The shared nurse care manager is a particularly innovative aspect of this effort, as described below.

Pennsylvania's program capitalizes on the Pennsylvania Chronic Care Collaborative, which is providing practices with free access to the RMD registry, related technical assistance, and educational programs. It also incorporates the six elements of the Chronic Care Model (i.e., self-management support, delivery system design, decision support, clinical information systems, community, and health systems).[3]

Team Structure

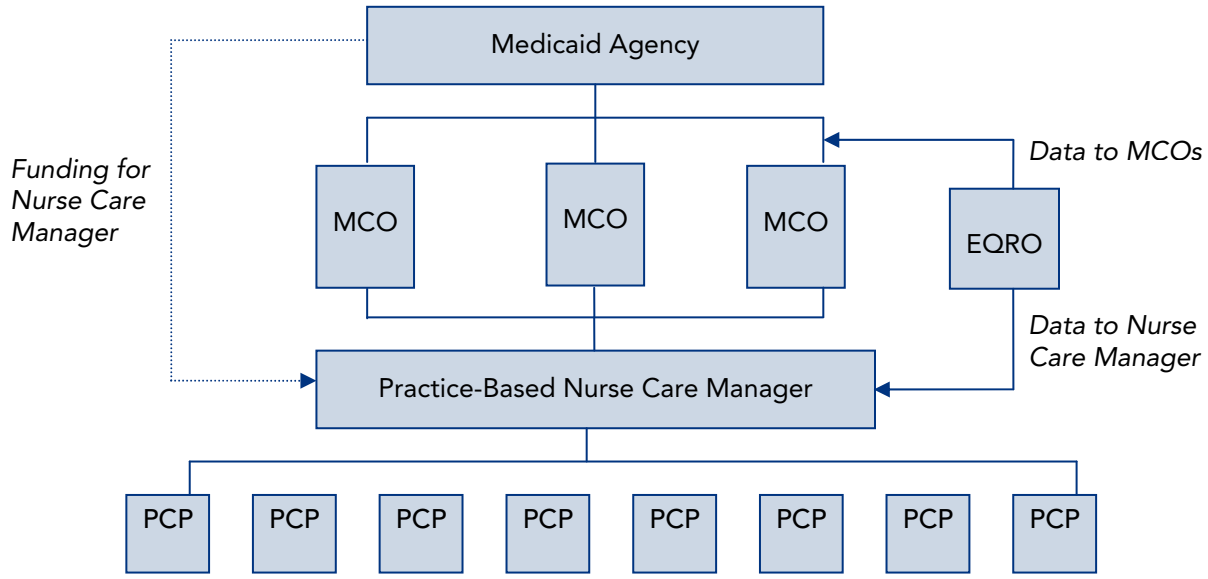
Pennsylvania's multi-stakeholder, collaborative team is led by OMAP. The three health plans managing the care of Medicaid beneficiaries in Philadelphia – AmeriChoice, Health Partners, and Keystone Mercy – are critical partners with the state. IPRO, Pennsylvania's external quality review organization, supports the team through data analysis, performance measurement, and identification of eligible practices.

The full-time nurse care manager is hired by the state, but works on behalf of all three plans to provide care management support and quality improvement facilitation to the participating practices (see Figure 1). This "plan-agnostic" nurse care manager reduces the fragmentation that otherwise occurs around quality improvement and care management when practices contract with multiple plans. Under separate contracts with multiple plans, providers are typically responsible for different quality improvement programs with different requirements and performance measures for different patient groups. This gives providers a weak quality improvement "signal," which they often disregard. Having one "messenger" with

[2] *ReachMyDoctor* is a service of RMD Networks, Inc. For more information, visit **www.rmdnetworks.com**.
[3] E.H. Wagner. "Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness?" *Effective Clinical Practice*, 1998;1:2-4.

a common quality improvement intervention and measure set for all Medicaid patients sends a much stronger message to each practice.

Figure 1: Team Structure for Pennsylvania's Project



The nurse care manager also provides practice-based care management – one of the resources most requested and needed by small practices – and helps to create linkages between the practices and care management resources available in the plans or community.

Financial Support

Participating practices receive financial incentives related to OMAP's existing pay-for-performance program, centered on reporting and improving performance in specific diabetes care measures. As part of the practice engagement effort, each practice receives information about the size of the financial incentive available.

Engagement and Assessment of High-Opportunity Practices

The eight practices participating in Pennsylvania's initiative all contract with the three MCOs. Eligible practices meet several criteria: they have five or fewer providers; 500 or more Medicaid beneficiaries; 60% racial/ethnic diversity in their Medicaid patient panel; 50 or more diabetic patients; and low performance on designated HEDIS 2008 measures for Medicaid managed care members.

The medical director of each participating MCO identified practices meeting these criteria. IPRO then contacted each plan to request member- and provider-level data for the HEDIS 2008 Comprehensive Diabetes Care measure for the Adult Access to Preventive/Ambulatory Health Services measure. IPRO aggregated the data, calculated performance at the practice level, and identified target practices. The team then further assessed practices in areas of infrastructure and medical management commitment.

To recruit target practices, representatives from OMAP outreached to the practices, sharing a "pitch package" on the program and the value of participation. Interested practices were invited to a formal dinner further introducing them to the program and to each other. The team delivered a presentation on the benefits of the program, its goals, and the responsibilities of participating practices. Each physician

received a confidential scorecard of his/her practice's diabetes measures, which included (blinded) comparisons to their peers.

Once practices committed to the program, they underwent a baseline assessment by the nurse care manager. Pennsylvania created its own practice assessment tool, which addresses practice management and chronic care processes. The nurse care manager administered this through direct questions of staff and her own observations across visits. The results help to identify each practice's "starting point" for intervention.

Registries: Identifying and Tracking Diabetic Patients

Pennsylvania is providing practices with access to the RMD patient registry. 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 web-based patient portal to foster patient engagement. RMD functions include automatic e-mail reminders to patients when they are due for care; patient contact information to reach those who are not using the web 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. The nurse care manager, who received training on the tool from the Pennsylvania Chronic Care Collaborative, will support the practices with initial implementation and population of RMD.

Practice Redesign: Providing Quality Improvement Supports

The nurse care manager will work with each practice in Year Two of the initiative to develop a tailored approach to improve care delivery. She will also work with the MCOs to identify additional care management resources at the plan or within the community to further support patient care.

Next Steps

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