CHCS Center for Health Care Strategies, Inc.

# Practice Supports: Using Care Managers and Quality Improvement Coaches to Transform Medicaid Primary Care

Technical Assistance Brief — May 2011

By Dianne Hasselman, Center for Health Care Strategies, Inc.

As health reform expands the Medicaid population by 16-20 million individuals over the next decade,[1] efforts to strengthen the primary care delivery system are increasingly critical, particularly for low-income populations. Small primary care practices, which serve high volumes of Medicaid beneficiaries and racially and ethnically diverse populations,[2] often lack infrastructure and staff needed to improve patient care delivery. These "high-opportunity" providers can particularly benefit from practice-based support around care management and quality improvement.

Emerging medical home initiatives designed to transform primary care are testing a broad range of interventions in practices across the country. One of the most promising interventions is deploying practice-based experts or "supports" to work one-on-one, on-site with practices for a limited amount of time. Depending on the unique needs of each practice, these experts have different skill sets and can be used to address the capacity and available resources of the Medicaid program.

This technical assistance brief outlines how states are using two types of practice supports to help Medicaid primary care practices provide higher-quality, more patient-centered, and cost-effective care. It draws from the experiences of states participating in *Reducing Disparities at the Practice Site*, a Center for Health Care Strategies initiative designed to support small, high-volume Medicaid practices, as well as additional states with innovative programs to support primary care. The brief describes:


## IN BRIEF

Many Medicaid beneficiaries receive their health care in small physician practices. Yet, these provider offices often lack the resources – infrastructure, staff, information technology, etc. – to focus on improved patient care delivery. This technical assistance brief describes how states are using two types of practice-based supports – care managers and quality improvement experts – to help Medicaid primary care practices provide higher-quality, more patient-centered, and cost-effective care. States exploring how to use new federal funding opportunities made possible through the Affordable Care Act, e.g., health home services, to reimburse practice supports for primary care providers, can learn from the experiences of states outlined in this brief.


1. Two key roles that practice supports can play;
2. Models for deploying these supports to primary care practices;
3. Different approaches that states are taking to hiring and paying for these individuals;
4. How Medicaid programs are using practice supports within a managed care delivery system; and
5. Early lessons that Medicaid is learning about these practice supports.

For purposes of this brief, *practice supports* are defined within two broad categories: individuals who help practices become better *functioning* organizations, and individuals who help practices *manage the care* of patients more effectively. Individuals in the first group are referred to by a variety of terms including quality

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improvement coaches, practice facilitators, and practice management consultants, among other terms. Their role can cover any task related to improving office management, functioning, and operations. Individuals in the second group are often referred to as nurse care managers, care coordinators, case managers, among other terms. Many have a clinical, i.e., nursing, background and thus, oversee any task related to managing the care of clinically complex patients.

While the responsibilities and skill sets (detailed below) vary and may overlap in these two types of supports, the importance of having the individual present at the point of care (i.e., within the office) is constant. By investing in primary care through these types of practice supports, Medicaid programs can aim to enhance chronic care management and achieve a positive return on investment through reduced use of avoidable and costly services. This approach can also help Medicaid in reducing the day-to-day chaos experienced by primary care physicians (PCPs) and strengthening a fragile primary care network.

## Roles of Practice Supports

High-volume Medicaid practices benefit from different kinds of support as they seek to transform care delivery. Individuals serving as practice supports can serve a variety of valuable roles, and while these roles may overlap at times, they require separate skills sets. As noted earlier, in general, there are two broad categories of practice support roles: individuals who help practices become better *functioning* organizations and individuals who help practices *manage the care* of patients more effectively. The descriptions below illustrate the variety of supports that any one practice may need.

**Improving Operations of Primary Care Practices**

- **Team building strategies and leadership skills.** There is growing recognition and acknowledgment that a functional office culture is critical, if not the key, to successful primary care practice transformation. Primary care offices must function well as a team with a strong clinical leader at the helm. Practice improvement coaches can assess existing office culture and teach invaluable skills to help practices work together more effectively.
- **Implementation and use of HIT.** Adoption and meaningful use of health information technology (HIT) is a top priority for high-volume Medicaid practices, given Medicaid's electronic health record (EHR) incentive program. In the last year, there has been significant "buzz" in the provider community regarding available incentive payments for high-volume Medicaid providers, with practices eager for support around HIT. Registries and EHRs are valuable tools for performance measurement, patient tracking, and quality improvement. PCPs need support not only in implementing these tools, but using the resulting data effectively on an ongoing basis.
- **Medical home certification.** Many primary care practices are interested in being certified as medical homes through the National Committee for Quality Assurance or a state-developed program. This

### What is Reducing Disparities at the Practice Site?

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.

State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania are implementing a unique model of leveraged practice improvement support for small, high-opportunity Medicaid practices. For more information, visit **www.chcs.org**.

effort requires substantial time and effort from the practice, and quality improvement coaches can provide that support.

- **Billing and practice management support.** Billing is often the first line of support deployed to practices, particularly small practices serving low-income patients. Experts in this area can help a small practice improve its fiscal health by working with front-desk staff, billers, and physicians to refine billing processes. They can assist with office redesign including documentation, development of office policies and procedures, and workflows. In sum, they can help create a less chaotic and better-functioning office.

**Improving Care Management Delivered within Primary Care Practices**

- **Chronic and complex care management.** The nurse care manager is typically one of the supports most sought after by practices. This is particularly the case for small practices, many of which do not have the resources to hire a nurse – a physician is often the only clinician on-site. As a result, chronic and complex care management, care transitions, and patient education simply do not get done. Having access to a nurse care manager – even on a part-time basis – is invaluable. A nurse care manager can spend time educating patients about chronic disease management, identifying and outreaching to patients who are overdue for services (e.g., routine diabetes care), connecting patients to social services available in the community, and helping physicians to improve quality outcomes.
- **Care coordination, case management, and community-based supports.** These individuals perform many of the tasks of the nurse care manager, but may not have a clinical background and are likely lower cost. Nevertheless, they are valuable resources for a PCP, particularly to help connect patients with social services and community-based supports.

Because there are two distinct skill sets – one focusing on office operations and one on patient care management – small practices can benefit most by having access to both supports, if needed, and in a phased-in manner. For example, a practice facilitator or quality coach might work first with the practice on getting the office to run more smoothly through HIT, panel management, and quality metrics before shifting to care management support. In other words, care management will be most effective if the practice has a well-functioning in the office that is able to easily identify its high-need complex patients and the services they have or have not received, etc.

Once they figure out *what* support small practices need for transformation, Medicaid programs and health plans must figure out *how* to provide the support. That is, how can they deploy, pay for, and designate effective work processes for practice supports?

## Deployment of Practice Supports

Practice supports can be provided in a variety of ways, depending on available program resources and the needs of participating practices. State Medicaid agencies can consider a model that deploys a team of coaches with distinct skill sets (e.g., New York City's PCIP example), or one that uses a single coach who can address as many elements as possible in a given practice.

Some Medicaid programs assign only one practice support to each provider site in order to form strong, long-term relationships. Gaining access and trust from a practice can take a significant amount of time, but is particularly important with small practices, where office dynamics can change considerably with the addition of a new teammate. This individual typically supports a caseload of five to 10 practices, depending on the intensity of practices' needs, the number of practices interested in support, and the availability of trained coaches. He or she rotates through the practices, perhaps spending one day, week, or afternoon a month in each office, depending on identified needs.

## Practice Supports in Action: *Pennsylvania, Michigan, New York, and Oklahoma*

**Pennsylvania** Medicaid deploys a nurse care manager to high-opportunity practices on a part-time basis. This nurse care manager is a "circuit rider" among 10 small primary care practices, spending on average half-a-day a week with each practice. She brings over 35 years of nursing experience and a certification in case management to her role. Her marketing and customer service skills are critical to gaining each practice's trust and buy-in. Motivational and team-building skills are equally important to identifying key personnel to manage the registry, take on responsibilities, and serve as internal project champions.

**Michigan's** Medicaid program is piloting practice supports within six small, high-volume Medicaid practices in Detroit. In this model, a "practice buddy" conducts an initial practice assessment, which includes an estimate of the practice's baseline patient-centered medical home (PCMH) level, and communicates the results to the practice. Each practice is using a registry that can accommodate multiple chronic conditions and serve all patients, regardless of payer. The practice buddy provides ongoing support for implementation of patient registries, including initially populating data and analyzing performance information from the registry. The practice buddy and the practice collaboratively develop a workplan that reflects the practice's priorities and strives to achieve at least Level 1 of the National Committee for Quality Assurance's (NCQA's) PCMH certification. The buddies support one another and the practices through a peer network that facilitates cross-practice sharing of concerns and best practices.

**New York City's Department of Health and Mental Hygiene** assembled teams of consultants to help small practices serving low-income patients, as part of its Primary Care Information Project (PCIP). The teams, which have experience in nursing, quality improvement, public health, informatics, pharmaceutical detailing and care management, replicate the pharmaceutical sales model by assigning practices to quality improvement experts by "territory."

**Oklahoma** is providing practice facilitators to 10 small primary care practices serving high volumes of Medicaid beneficiaries to improve chronic care delivery. The practice facilitators are registered nurses with at least a bachelor's in nursing; several have master's degrees. All have worked in a practice setting; some have case management experience, and many have a social work background. Facilitators help each practice improve chronic illness care by assessing practice capacity and establishing patient care processes that use evidence-based guidelines and quality measures.

Oklahoma's practice facilitators perform a variety of functions, such as: (1) coordinating weekly meetings to update practice staff on goals, progress, and performance; (2) completing periodic practice assessments; (3) conducting staff interviews; (4) performing chart abstractions and process mapping; and (5) teaching staff to implement, monitor, and modify the Plan-Do-Study-Act cycle to support quality improvement goals. The facilitators also support use of the CareMeasures web-based patient registry,[3] including populating the registry with data on diabetic patients and teaching staff how to enter, update, and report data. They give practices ongoing feedback, identify areas for improvement, and help determine priorities and an action plan to improve care delivery.

Practice supports may or may not have a designated workspace at the practices they serve (small practices in particular are short on space), and typically invest a finite amount of time in each practice. They generally impart a needed skill set over a series of visits, and then move on to the next practice in need. For example, a quality coach might work frequently and intensely with a practice during initial implementation and use of a registry, and then taper off work to the next practice. Some coaches re-deploy, for example, if practice staff turnover or if there are significant changes in a practice operations. Coaches will also re-deploy to provide "refresher" courses to practices as needed.

Deployment of a nurse care manager or care coordinator is more challenging because the skill set may or may not be transferable to practice staff, unlike the quality coach or practice facilitator. In other words, while the practice can "institutionalize" data entry and reporting or new billing practices, it is more difficult in a small practice to institutionalize complex care management or care transitions, for example, without hiring a new staff person. Certainly some patient education and chronic care management activities can be performed by a

medical assistant; however, the more complex the patient's clinical situation, the greater the need for a trained care manager.

## Hiring and Paying for Practice Supports

There are a variety of ways that Medicaid can hire and pay for practice supports. For example, a state can contract with a third party to provide these services. Oklahoma Medicaid contracts with the Iowa Foundation for Medical Care to hire, train, and deploy practice facilitators to primary care providers in need of quality improvement support. Likewise, in North Carolina, the Medicaid agency provides funding to pay for care managers who deploy to practices through the Community Care of North Carolina networks.

Hiring practice supports can be more complex in a managed care delivery system where practices contract with multiple health plans. From the practice perspective, it would be confusing and inefficient to have multiple care managers or multiple quality improvement coaches deployed to an office (particularly one that is short on physical space.) Having one shared practice support resource person who thus represents some or all Medicaid plan members is critical. Michigan and Pennsylvania Medicaid managed care programs are both testing this "shared supports" approach.

Pennsylvania's Medicaid program initially intended to have the three Philadelphia-based health plans jointly hire and fund a nurse care manager to work with high-volume Medicaid practices; however, the administrative complexities of such an arrangement created an obstacle (e.g., who would ultimately be responsible for hiring, providing benefits, providing office space?) Instead, the state contracted directly with a nurse care manager to represent all three plans.

In contrast, the Medicaid team in Detroit, which includes six health plans, leverages quality resources that already reside within the six health plans that contract with the state. Each plan deploys a practice buddy – a senior-level quality improvement leader – to work with an individual practice on behalf of all six plans. The participating practices hold contracts with at least five of the six plans.

Through Rhode Island's Chronic Care Sustainability Initiative, the health plans participating in Medicaid partner with commercial payers to cover the salary and benefits of an on-site nurse care manager for each practice in its pilot program. The nurse care managers work on-site as an employee of each practice, and see patients of all insurers. The initiative recently added a hospital and its seven affiliated primary care practices. The hospital will serve as the "hub" for its practices and will employ and deploy nurse care managers to its practices.

Vermont is also providing practice-based supports to practices participating in the state's multi-payer PCMH initiative. Locally designed community health teams help manage the care of patients, while Medicaid has repurposed some of its care managers to "float" among practices with a high volume of Medicaid patients.

Other models for providing practice supports that states can explore include:

- Repurposing staff from a health plan or disease management program from being plan- or telephonic-based to being practice-based;
- Contracting with a state medical society or quality improvement organization to provide practice facilitators;
- Collaborating with multi-payer medical home initiatives around shared practice supports; or
- Using emerging Medicaid health homes to fund and deploy practice-based care management supports to high-volume Medicaid practices.

## Deploying Practice Supports: *New York, North Carolina, Pennsylvania, and Oklahoma*

The **New York City-based Primary Care Information Project (PCIP)** is seeking to improve health care quality in underserved communities through health information technology. The PCIP program deploys a multi-disciplinary team of consultants to participating practices, including billing, HIT, and care management experts. Practices have access to a variety of services and expertise as needed.

The **Community Care of North Carolina** network deploys a case manager to high-volume Medicaid practices to provide support for complex patients. The case managers visit each practice monthly to link patients and providers to community resources; deliver group and individual diabetes education; make referrals to specialty case managers; and improve workflow processes.

The Area Health Education Center, which is also North Carolina's regional extension center for EHRs, provides each practice participating in the program with an HIT expert to assist with registry implementation, and performance measurement and reporting. To support this work, the coaches conduct baseline assessments of practice features and chronic care delivery through on-site interviews and direct observation. After sharing their findings with each practice, the coaches develop tailored work plans. They help each practice implement and use the *ReachMyDoctor* electronic patient registry tool and generate subsequent outcomes data.

North Carolina's case managers and practice coaches coordinate their work to have an optimal impact on participating practices. For example, when the registry identifies opportunities to improve a diabetes metric, the case manager works with the practice coach to implement diabetes-related quality improvement strategies.

In **Pennsylvania**, the Medicaid program's nurse care manager spends four to 12 hours per week within several small, high-volume Medicaid practices to:

- Review charts for diabetics at high-risk for complications or overdue for health screenings, and provide them with telephonic disease management;
- Teach the office staff how to use the *Reach My Doctor* electronic patient registry;
- Help to link the practice and patients to plan- and community-based care management resources; and
- Educate practices about how to qualify for each health plan's pay-for-performance program (e.g., for performing HbA1c tests).

**Oklahoma** deploys one practice facilitator to each targeted practice, working hard to establish long-term and trusted relationships. The practice facilitators have backgrounds in nursing and experience working in private practices. They are well-versed in Oklahoma's registry, quality improvement, team-building, and care management goals, and visit each practice every two to three weeks for a period of five to 10 days. Project leaders are continually assessing and modifying the focus and frequency of support from the practice facilitators, to respond to each practice's changing needs. For example, while facilitation initially focused on implementing a few major changes in each practice, the team found that numerous smaller process changes were more manageable and sustainable for the practices; the facilitators shifted their focus accordingly.

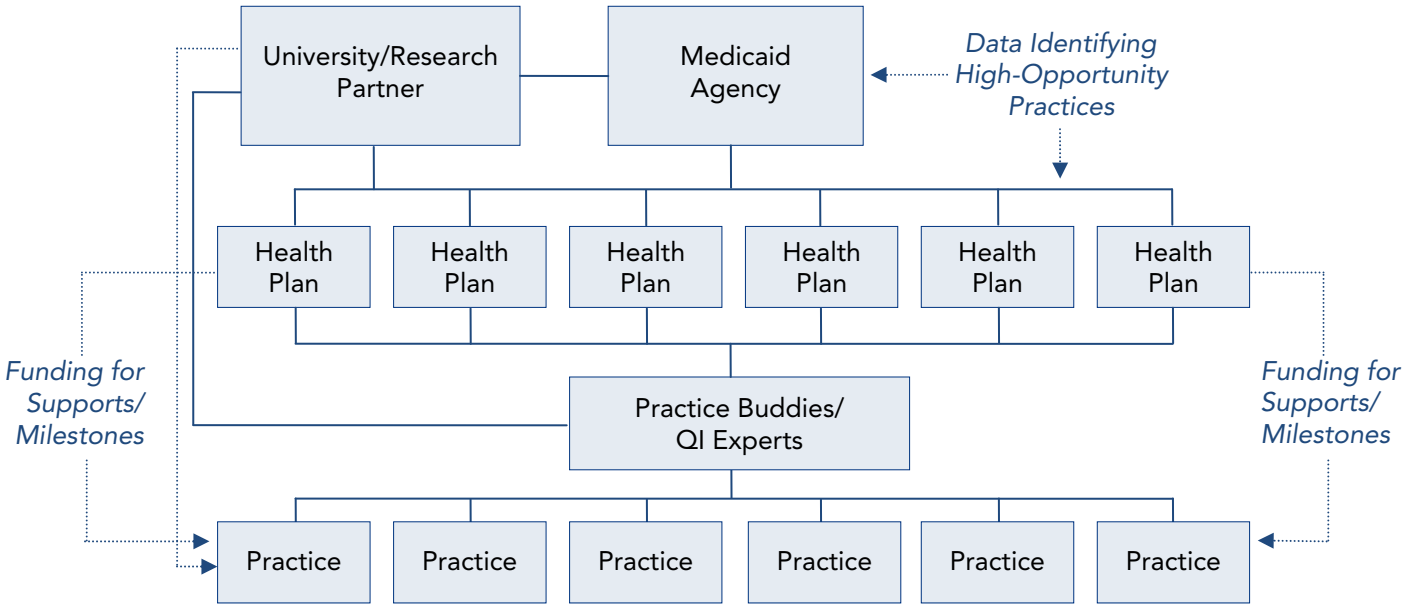
## Practice Supports in a Managed Care Delivery System

A private primary care practice typically holds contracts with many health plans representing different payers and products. The varying quality measures or medical home requirements in these contracts can lead to a confusing patchwork of ineffective quality improvement programs at the point of care. Alternatively, Medicaid managed care programs can approach quality improvement in a way that is "agnostic" of individual

plans – providing one on-site expert only. This is particularly important in small practices, which may have difficulty accommodating multiple on-site experts.

Michigan, Rhode Island, and Pennsylvania are using different models to implement a plan-agnostic approach. As described previously, in Detroit (see *Fig. 1)*, each health plan deploys a senior quality improvement staff person to a participating practice. This staff person, the practice buddy, represents all of the Medicaid health plans contracting with that practice. He or she assesses the practice's needs and shares results with all of the plans. The practice buddy also supports achievement of Level 1 PCMH for all patients, not just members of one health plan. A university with a health care research department provides training, support, and standardization across the program for the practice buddies.

***Figure 1*: Team Structure for Michigan's Practice-Support Project**

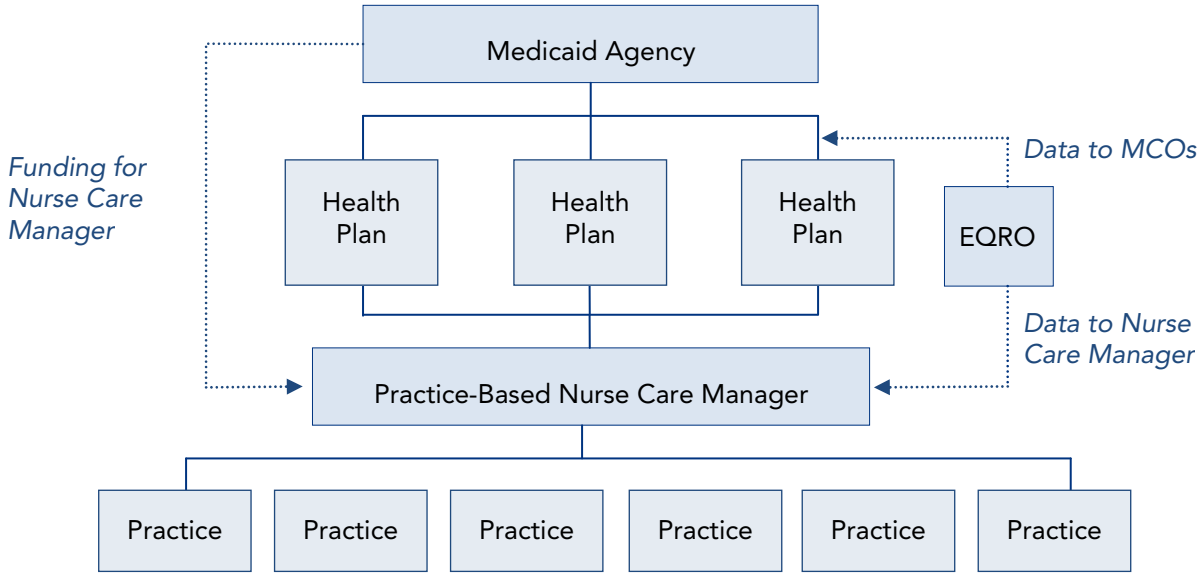



In contrast, Pennsylvania Medicaid hired a full-time nurse care manager to support diabetes-related care processes in several high-volume Medicaid practices. The nurse care manager works on behalf of the program's three participating health plans (see *Fig. 2*) and uses a common quality improvement intervention and measurement set to send a consistent message to practices.

Pennsylvania's nurse care manager rotates among the participating practices to provide hands-on support. She is responsible for outreaching to and recruiting practices on behalf of the team. She meets face-to-face with each practice to communicate the quality improvement and care management support she can provide. Subsequently, she performs baseline assessments of practice management and chronic care processes – directly questioning and observing staff to identify the starting point for intervention.

As described above, Rhode Island also adopted a plan-agnostic approach. The plans, including those serving Medicaid, contribute financially to the salary and benefits of a nurse care manager for each practice participating in the medical home pilot. The practices then have the freedom to select the right nurse care manager for their practice, and he or she manages the care for panel patients, regardless of the insurance carrier.

*Figure 2:* **Team Structure for Pennsylvania's Practice-Support Project**




## Early Lessons Learned

The innovative practice-support models being tested in Medicaid that are highlighted in this brief yield valuable early lessons.

1. ***It's hard to get in the door. That said, getting in the door is only part of the battle.*** Logistically, it can be difficult to reach the practices, as very few have computers or e-mail accounts. It is also tough to overcome initial practice mistrust or resistance, and to become a valued member of the practice team. Providing a practice with quality improvement support that provides value can help overcome these barriers. While many practices are eager for nurse care management support, they are less receptive to quality improvement assistance which is critical to true transformation. A practice improvement expert needs to have a strong business case for quality improvement and investment.
2. ***Creating a "cultural shift" within high-volume Medicaid practices is challenging, but also incredibly rewarding.*** Getting a practice to embrace the need for transformation activities is perhaps the most difficult challenge. Many high-volume Medicaid practices are too overwhelmed with the "hamster wheel" of day-to-day patient care to invest in quality improvement activities. Implementation of a patient registry or EHR requires significant time, energy, and resources – all of which are in short supply in Medicaid practices. However, it often just takes one practice champion to recognize the need for change and the benefits of support to seed the cultural shift necessary to support practice-wide transformation.
3. ***Not every high-volume Medicaid practice is ready to embrace practice transformation.*** Many factors can affect a practice's readiness for transformation, particularly practice culture and clinical leadership. Critical practice characteristics include: staff receptivity or resistance to external support; a practice-wide commitment to quality improvement; and the tenor of relationships between physicians and support staff. Practice infrastructure, including adequate workspace and technology, also affects readiness. Organizations should explore these factors before devoting resources to practices that may not be able to benefit from them.
4. ***Practice-based care management can move the quality needle.*** Practice-support pilots are beginning to show positive outcomes, particularly in quality of care. Medicaid pilots in Philadelphia and Oklahoma are showing promising preliminary results in quality improvement and utilization measures.

5. ***Medicaid and other payers should collaborate around who is deployed to practices, including a coordinated message, materials, and tools.*** After decades of neglect, primary care practices are finding themselves barraged with opportunities such as the medical home, pay for performance, EHR implementation and meaningful use, and other quality improvement initiatives. Needless to say, small practices in particular find this attention overwhelming and confusing. A unified message provides a stronger and far clearer impetus at the practice level.
6. ***Health plans are valuable partners, but face challenges in providing on-site support.*** While Medicaid health plans can provide valuable supports such as aggregated claims data, HIT, and funding for quality improvement, they have less experience with deploying on-site support specifically for quality improvement or care management. Furthermore, provider skepticism of health plan motives may hinder effective partnerships. Health plans would thus be wise to explore innovative strategies to support practices.
7. ***Midcourse corrections are a necessary and valuable step.*** After working with practices for two years, Pennsylvania decided that the sites would benefit from enhanced assistance around practice management and billing—which the nurse care manager could not provide. The state is contracting with a practice management organization to provide this expertise to interested practices. Similarly, Michigan's practice buddies struggled to accommodate the time needed to work with each individual practice, and subsequently contracted with an organization to provide more intensive practice management and PCMH-certification support.
8. ***Much has been learned, but many unknowns remain.*** Increasingly, Medicaid programs are finding answers regarding the needs and capabilities of small, high-volume Medicaid practices. However, many questions remain, including: 1) the right level of intensity and frequency of support; 2) the best way to motivate and create the cultural shift needed to transform hard-to-reach practices; and 3) how to create a sustainable source of funding for quality improvement and care management supports at the practice site.

## Conclusion

The Affordable Care Act (ACA) has brought new federal investments to the long-neglected primary care arena. One of the most promising provisions gives Medicaid programs the opportunity to reimburse six new care management-related services, called "health home" services. States are exploring how this funding opportunity can be used to fund practice-based care management supports in particular, as described in this brief.

With Medicaid enrollment expected to increase by up to 20 million beneficiaries over the next several years, and new federal funding available through health reform, Medicaid has a tremendous opportunity to improve the primary care delivery system for Medicaid beneficiaries. Notably, practice supports paid for by Medicaid will typically have a "spillover effect" for other payers. Thus, the efforts of a practice management expert, quality improvement coach, or HIT expert will potentially help improve practice capacity for all patients, not just those enrolled in Medicaid.[4] As such, innovative state agencies that invest in practice supports for high-volume Medicaid practices are building infrastructure for a larger, and sorely needed, ambulatory quality improvement effort across the health care system.

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

Visit **www.chcs.org** for additional resources and tools.

## Endnotes

[1] Congressional Budget Office analysis of the Reconciliation Act of 2010 in a letter to Nancy Pelosi, March 20, 2010; *Estimated Financial Effects of the "Patient Protection and Affordable Care Act of 2009" as Proposed by the Senate Majority Leader on November 18, 2009*. Centers for Medicare and Medicaid Services, Office of the Actuary. December 10, 2009.
[2] J. Moon, R. Weiser, N. Highsmith and S.A. Somers. *The Relationship between Practice Size and Quality of Care in Medicaid*, Center for Health Care Strategies. July 2009. Available at www.chcs.org.
[3] CareMeasures is a CMS Physician Quality Reporting Initiative qualified electronic patient registry. For more information, visit https://www.caremeasures.org/CareMeasures/public/Default.aspx.
[4] Note: This is true for practice improvement experts with the exception of Medicaid-specific nurse care managers.