

Reducing Disparities at the Practice Site: Supporting Small Practices in Improving Care Delivery

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CHCS Mission

To improve 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.

▶ **Our Priorities**

- Improving Quality and Reducing Racial and Ethnic Disparities
- Integrating Care for People with Complex and Special Needs
- Building Medicaid Leadership and Capacity

▶ **National Reach**

- 47 states
- 160+ health plans



Reducing Disparities at the Practice Site

- A national initiative designed to:
 - ▶ Support quality improvement in small practices serving a high volume of racially and ethnically diverse Medicaid beneficiaries
 - ▶ Reduce disparities in diabetes care
- 40 small, primary care practices in Michigan, North Carolina, Oklahoma, and Pennsylvania
- Testing new models of practice site improvement in small, “low resource” primary care practices
- 3-year initiative (with 9-month planning phase)
- Led by the Center for Health Care Strategies, with funding from the Robert Wood Johnson Foundation

Why Medicaid?

Health Insurance Coverage*

- 30 million children
- 15 million adults in low-income families
- 14 million elderly and persons with disabilities
- 8.8 million aged and disabled “dual eligibles” (19% of Medicare beneficiaries)

MEDICAID
\$361 billion annual cost

Federal Spending

16% of national health spending
44% of all federal funds to states

State Spending

25% of state budgets spent on
Medicaid

*Numbers are not additive.

Source: Kaiser Commission on Medicaid and the Uninsured, 2008

Medicaid's Challenges and Opportunities

67 million	People in the United States who will receive Medicaid benefits in 2009.
\$364 billion	Estimated 2009 costs for Medicaid.
41%	Births in the U.S. covered by Medicaid.
28%	Children in the U.S. covered by Medicaid.
50%	Medicaid beneficiaries under 65 who are racially and ethnically diverse.
46%	Adult Medicaid beneficiaries who have more than one chronic condition.
4%	Medicaid beneficiaries who account for 50% of total Medicaid spending.
43%	Medicaid beneficiaries with behavioral health comorbidities.
60%	Medicaid recipients who are enrolled in managed care.

Why Small Practices?

- 60 percent of all physicians work in practices with four or fewer providers;¹
- 66 percent of physician office visits occur in practices of four or fewer providers;²
- Small practices have a growing and increasingly older patient load;³
- Quality improvement efforts are often hindered by poor reimbursement and inadequate staff support;⁴ and
- Few programs are focused on quality in small practices, despite the practices' role in providing much of the primary care in the U.S.⁵

1 American Medical Association

2 2004 National Ambulatory Medical Care Survey

3 Baron, R.J., Sept. 16, 2008 (presentation). "A Patient centered medical home in RI: what's the big deal?"

4 Audet, A.J, Doty, MM, Shamasdin, J, and Schoenbaum, SC (May/June, 2005). Measure, learn and improve: physicians' involvement in quality improvement. *Health Affairs*; 24(3): 843-853.

5 Center for Health Care Strategies, Inc., October 2008. "Reducing disparities at the practice site: kick off meeting opening presentation."

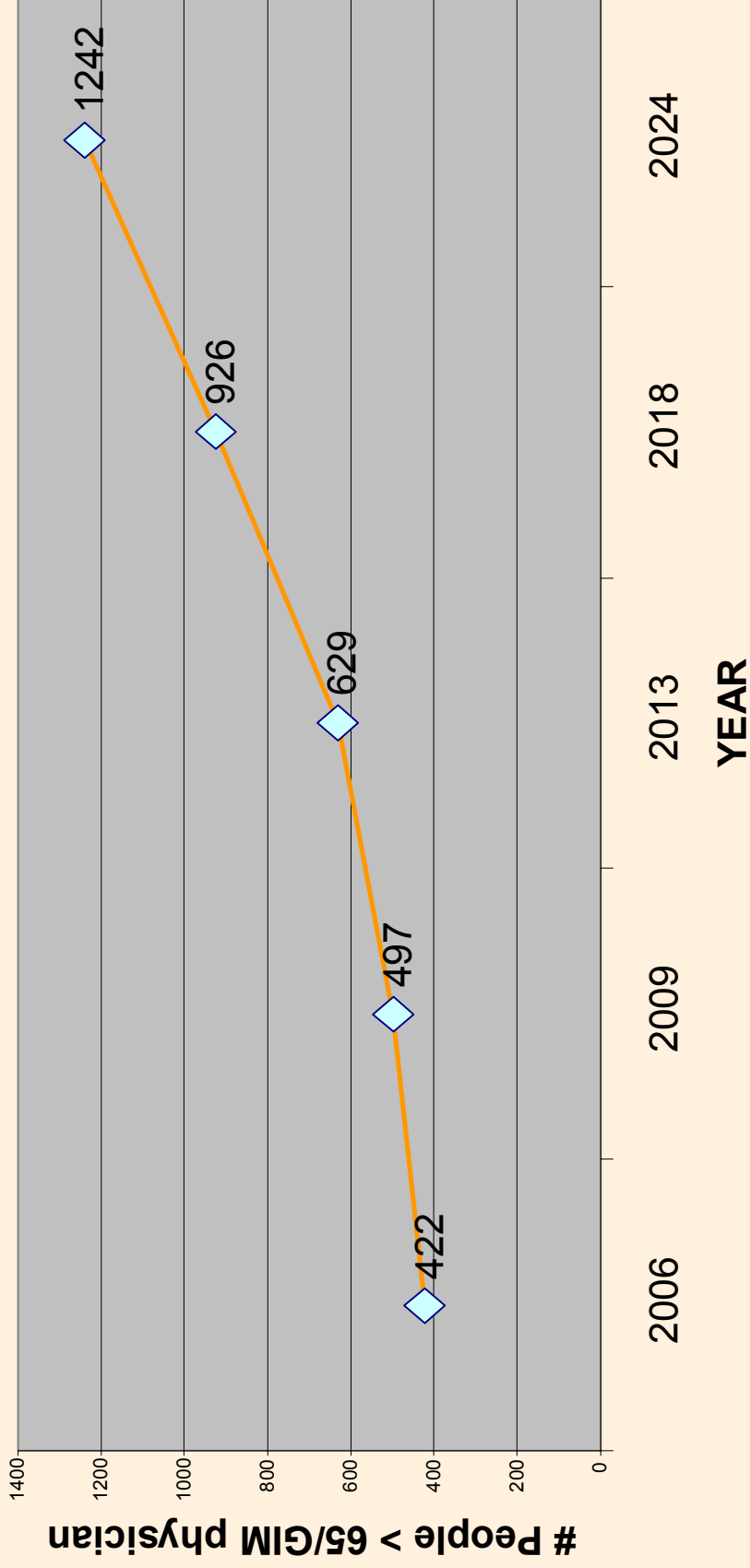
Status of “General” Internal Medicine and Primary Care

- Dramatic decrease in medical students choosing internal medicine
- Only 23% of 2007 graduating medical students chose internal medicine (of those, only 2% in primary care) and 4.9% in family practice
- 10 years after initial certification, only 79% of those with internal medicine certification still in practice, compared to 98% with subspecialty certification

Note: Slide from R. Baron, MD, Former Chair of ABIM

Fewer GIM and Aging Population Result in Increased Patient Load Per GIM

Number of people >65/GIM physician 2006-2024



Note: Slide from R. Baron, MD, Former Chair of ABIM

Research on Disparities

- Low-performing hospitals tend to serve a larger proportion of minority patients;¹
- Physicians serving a large percentage of minority patients are less likely to be board certified and more likely to report that they are unable to provide high-quality care to all their patients;² and
- Quality outcomes for Medicaid beneficiaries are typically 10% to 20% lower than for commercial patients.

¹ R Hasnain-Wynia, DW Baker, D Nerenz et al. Where Minority Patients Seek Care. *Arch Intern Med.* 2007;167(12):1233-1239.

² PB Bach, HH Pham, D Schrag, RC Tate, JL Hargraves. Primary Care Physicians Who Treat Blacks and Whites. 2004;351(6):575-584.

Tools for Supporting Small Practices

Leadership and Change Management	Coaching and mentoring to depart new skills
Social Network	Facilitating new social linkages
Chronic Care Education	Implementing practice-based chronic care tools
Enhanced Payment	Providing up-front enhanced payment
Health Information Technology	Implementing e-Rx, registries, EHRs
Data	Providing aggregate and member-level health plan data
Nurse Care Manager	Deploying practice-based care manager
Practice Facilitator	Deploying practice-based quality improvement facilitator

Reducing Disparities in Detroit

- Six health plans are aligning efforts by:
 - ▶ Identifying and engaging with six small, high volume Medicaid practices
 - ▶ Talking with practices to understand their needs, challenges, and priorities
 - ▶ Providing financial support to practices interested in becoming patient centered medical homes
 - ▶ Helping practices select and implement a registry to measure and improve patient care
 - ▶ Designating a quality improvement “coach” – representing all 6 plans – to provide one-on-one support to each practice
 - ▶ Providing NCQA’s PCC-PCMH training and tools to participating practices

Reducing Disparities in Oklahoma

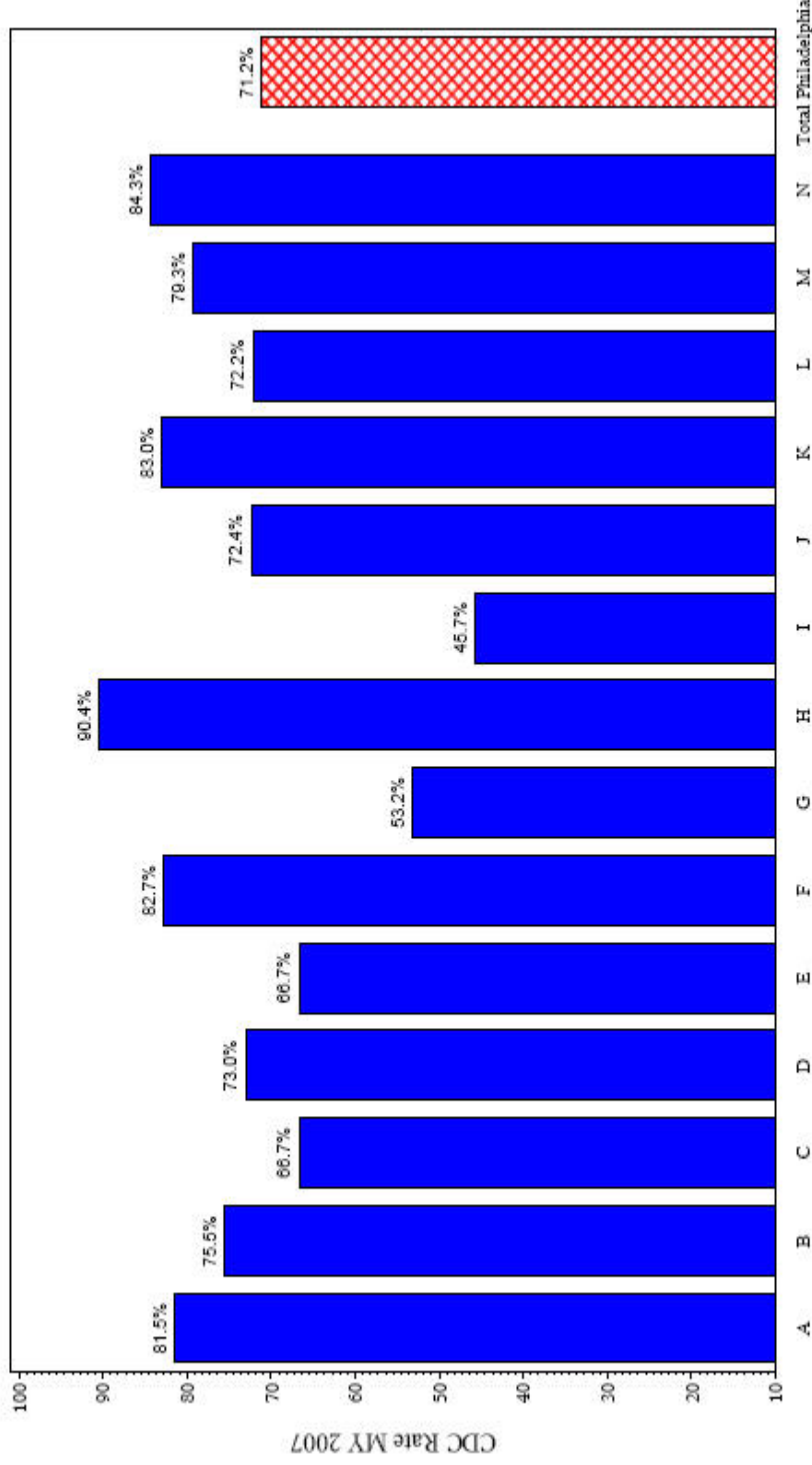
- 10 small primary care practices across the state
- Oklahoma Health Care Authority (Medicaid) is:
 - ▶ Identifying and reaching out to participating practices;
 - ▶ Providing financial incentives to practices for participation in program;
 - ▶ Supporting a quality improvement facilitator to work with each practice; and
 - ▶ Convening regular QI collaboratives for practices.
- Iowa Foundation for Medical Care (IFMC) facilitators are:
 - ▶ Working with practices to understand their priorities and identify opportunities to improve workflow;
 - ▶ Implementing the CareMeasures registry tool and using data to better understand and improve care delivery; and
 - ▶ Providing ongoing support to practices in quality improvement.

Reducing Disparities in Philadelphia

- Three health plans in Philadelphia are aligning efforts by:
 - ▶ Identifying 10 high Medicaid volume small practices
 - ▶ Jointly supporting a full-time Nurse Care Manager to work with practices in redesign and care management
 - ▶ Populating and implementing *Reach My Doctor* registry
 - ▶ Offering collaboratives to participating practices
 - ▶ Offering financial incentives through P4P program

Even Within Homogenous Practices in Philadelphia, Wide Disparities in Care Exist

Reducing Disparities at the Practice Site (RDPS)
 Pennsylvania Medicaid Managed Care (MMC)
 Measurement Year (MY) 2007
 Comprehensive Diabetes Care (CDC)
 Numerator: Hemoglobin A1c Tested



RDPS Primary Care Practice Site

Note: Total Philadelphia is based on the member's zip code as provided by the MCOs on the MY 2007 RDPS CDC member level data files.
 Run Date: December 2, 2008
 Health Care Strategies, Inc.

Insights from Initial Efforts

- This is tough but rewarding work!
- State/plan ability to collect/aggregate rich data at practice level.
- Challenge of creating a “standardized” practice support model, particularly within the managed care delivery system.
- Medicaid health plans “get it” as evidenced by commitment to collaboration.
 - ▶ That said, it is challenging to develop a uniform program.

Insights from Initial Efforts

- There's tremendous opportunity for plans to support practices (e.g., care management, access, outreach, performance data, etc.)
- Non-physician staff are an important key to a practice's success in transforming.
- Practices need both *QI expert and nurse care manager* – can one person fill two roles?
 - ▶ Regardless, clinical experience working within a practice is critical.
 - ▶ Must strike balance between “soft” philosophical relationship and “hard” analytical tasks.

Initial Feedback from Practices

- “I’m not being judged. I’m being helped.”
- This is an opportunity to address a practice’s “isolation” .
- Financial incentives play a small role.
 - ▶ It’s about mission, community, and the “need to upgrade my practice” .
- Practice support...
 - ▶ Most feared (but also most valued) = registry/EMR
 - ▶ Most wanted = nurse care management
 - ▶ Most unknown = practice facilitator
 - ▶ Most likely to be needed = payment incentives/payment reform

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