

Advancing Primary Care:
Minnesota Practice Assessment Results Report

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BACKGROUND

Communities across the country are attempting to design and implement advanced primary care models, using principles from the patient-centered medical home and focused on changing the delivery of chronic care. However, research is scant on the ability and capacity of “high-value” physician practices – those serving a high proportion of Medicaid patients or a high volume of racially and ethnically diverse populations – to undertake such practice transformation. As health care reform leads to an expected increase of 16 to 20 million Medicaid beneficiaries starting in 2014, the role of these practices will become even more critical and expansive in reach. Understanding how high-value practices currently perform on elements related to advanced primary care models can enable communities to better target ambulatory quality improvement efforts and improve care delivery. In addition, state Medicaid agencies can use such information to prepare the primary care system for health care reform implementation.

Key Regional Findings

- Minnesota performed better than the national mean on most practice dimensions;
- Scores related to Ongoing Care, Coordination, and Delivery System Redesign were lower than the national mean; and
- Access, Coordination, and Decision Support are most strongly associated with quality of care measures.

The Center for Health Care Strategies (CHCS) worked with five *Aligning Forces for Quality (AF4Q)* communities (Cleveland, Kansas City, Maine, Minnesota, and Puget Sound) and Medicaid agencies in two states (Arkansas, Oklahoma) to undertake the *Advancing Primary Care* assessment. Designed to identify regional and national trends in practice capacity, results are intended to help participating communities to:

- (a) Better understand the strengths and opportunities for improvement for a key segment of their provider market;
- (b) Begin to assess what type of education, training, and support these high-value practices might need; and
- (c) Start to design interventions in partnership with Medicaid to assist practices that are facing significant challenges in meeting performance targets.

SURVEY METHODOLOGY

Survey Instrument. To develop the practice assessment survey used in this study, CHCS conducted a comprehensive review of existing measures and subsequently selected components from three existing, validated tools: 1) the *Primary Care Assessment*

Tool (PCAT);ⁱ 2) the National Committee for Quality Assurance’s (NCQA) *Physician Practice Connections® Tool – Research Version*;ⁱⁱ and 3) leadership questions developed at Case Western Reserve University.ⁱⁱⁱ CHCS developed additional questions to explore practice demographic characteristics, health information technology (HIT), and barriers and facilitators to implementing quality improvement strategies.

The resulting survey was designed to assess practice capacities along 13 dimensions reflecting key features of care delivery that, taken together, encompass high-quality, patient-centered care (see Table 1). CHCS asked practices to evaluate the frequency with which these features are incorporated into their day-to-day practice of medicine.

Table 1: Practice Dimensions Assessed by Survey

Survey Dimension	Key Features	Sample Question
1. First contact: Access	Same-day appointment, after-hours access, phone advice	When your facility is open and patients get sick, would someone from your facility see them that day?
2. Ongoing care	Personal provider, continuity of provider	Do the clinicians know the patients who use your facility “very well”?
3. Coordination	Referrals to other providers, follow-up to referrals	When patients are referred, do the clinicians give them any written information to take to the specialist?
4. Comprehensiveness: Services Available	Immunizations, family planning/birth control services, counseling for behavior or mental health problems, suturing for minor laceration on-site	If patients need any of the following services, would they be able to get them on-site at your facility?
5. Comprehensiveness: Services Provided	Home safety, advice about prevention, counseling on family issues	Are the following subjects discussed with patients?
6. Family-centeredness	Meet with family members, seeking opinions	Does your office ask patients for ideas and opinions when planning treatment and care for the patient or family member?

7. Community orientation	Home visits, knowledge of community, consumer input, networking	Do you think the clinicians at your facility have adequate knowledge about the health problems of the communities you serve?
8. Culturally competent	Communication, health beliefs	If needed, does your facility take into account a family's special beliefs about health care or use of folk medicine, such as herbs/homemade medicines?
9. Leadership	Team environment, responsiveness to change, leaders open to input	Does practice leadership make sure that people in this practice have the time and space necessary to discuss changes to improve care?
10. Health System	Performance measurement, feedback to physicians on quality of care, formal quality improvement activities	Does your organization provide data to individual physicians on the quality of their care (or care across the practice site) for patients with specific chronic conditions?
11. Delivery System Redesign	Primary care teams, non-MD educator/nurse manager for condition, pre-visit planning, post-visit follow-up, follow-up on missed appointments	What components of care management are routinely provided to your patients with chronic illness (either through your organization or through a health plan or external organization)?
12. Clinical Information Systems	Registries, problem lists, medication lists, flow sheets for condition, checklists of tests and interventions, patient assessment questionnaire, test or referral tracking systems	Does your organization maintain a registry (a list of patients with a particular condition along with associated clinical data for each patient)?

13. Decision Support

Adopted guidelines for condition treatment, clinician reminders for condition care, abnormal test alerts for clinicians

Does your organization have guideline-based reminders for services any patient should receive when being seen, for example as pop-ups within an EMR or as a paper attached to the front of the chart?

Recruitment of Participating Regions. CHCS invited *AF4Q* Alliances, as well as Medicaid agencies from Arkansas and Oklahoma, to apply for participation in the current study. To qualify, an Alliance was required to have: 1) practice-level Medicaid performance data, and 2) the ability to identify high-value practices.

Practice Identification and Selection. The participating Alliances and Medicaid agencies identified high-volume Medicaid practices in their regions that met the following criteria: 1) 20% of patients in the practice were enrolled in Medicaid, or the practice had approximately 500 Medicaid patients per physician; *or*, 30% of patients in the practice were enrolled in Medicaid or uninsured, or the practice had approximately 700 Medicaid/uninsured patients per physician; 2) a stand-alone, physically bound location; and 3) a family practice, internal medicine, or nurse practitioner (excluding pediatric-only practices and physician assistants). Practices in fee-for-service and/or managed care delivery systems were included.

Fielding of the Survey. CHCS fielded the survey from March through September 2010, aiming to assess 171 practices. A lead medical provider/medical director and an office/practice manager were identified in each practice and asked to complete independent surveys. As of November 1, 2010, CHCS had received at least one completed survey from 126 practices (a practice response rate of 74%). The national data included in this report are based on cleaned and processed data from 120 practices from six of the participating regions (Kansas City data were not included in the national mean calculations). For these analyses, CHCS used survey responses from the lead medical provider if provided, and from the office manager if not. At least one completed survey was received from 26 practices in Minnesota (see Appendix A), for a regional response rate of 76.5%. Seventeen of the surveys used in this analysis were completed by medical providers.

Quality Data. Minnesota Community Measurement (MNCM) provided all-payer quality data concerning management of diabetes and vascular disease for 24 of the 26 responding practices. Analyses in this report used the “optimal care” measures for both

diseases. For diabetes, optimal care was defined as the percentage of diabetes patients ages 18-75 who met all of the following targets:

- The most recent HbA1c in the measurement period has a value <8.0.
- The most recent LDL test in the measurement period has a value <100.
- The most recent blood pressure in the measurement period has a systolic value of <130 *and* a diastolic value of <80.
- There is chart documentation that the patient is not a current tobacco-user.
- If the patient is age 41 or older, there is documentation in the measurement period that the patient is on daily aspirin, or that there is an accepted contraindication (any date).

Optimal vascular care was defined as the percentage of ischemic vascular disease patients ages 18-75 in the measurement period who met all of the following targets:

- The most recent LDL test in the measurement period has a value <100.
- The most recent blood pressure in the measurement period has a systolic value of <130 *and* a diastolic value of <80.
- There is chart documentation that the patient is not a current tobacco-user.
- There is documentation in the measurement period that the patient is on daily aspirin or there is documentation of an accepted contraindication.

Characteristics of the Minnesota sample. Respondents answered several questions about their individual and practice characteristics (see Appendix B). Answers revealed that the majority of respondents in Minnesota were medical directors and clinic directors, and most practices were multi-specialty group facilities, within a community health clinic or hospital clinic. Respondents practiced primarily general practice/family medicine, primary care subspecialties, and a combination of general practice and internal medicine. Most practices were reimbursed through fee-for-service payments, and served a fairly equal distribution of Medicaid, private, and Medicare patients.

STUDY RESULTS

Survey Dimensions. Table 2 compares Minnesota regional means with national means (i.e., across the six regions included in the study). It also illustrates “absolute” gaps with respect to optimal scoring along the 13 dimensions. CHCS defined such gaps as scores that are at least 25% below the highest achievable score (e.g., on a scale of 1-4, a score of 3 or less).

Overall, Minnesota scores were above the national mean on most dimensions, with the exception of Ongoing Care and Coordination. Reinforcing this latter quantitative finding, one respondent noted the need for “more case management/social workers in clinic to talk to patients while they are here.” Another respondent thought that

“improving health follow-through (taking diabetic meds, mammograms, etc.) for culturally diverse/non-English speaking patients” was an important area requiring additional effort.

CHCS identified absolute gaps in Minnesota scores for Ongoing Care, Coordination, and Delivery System Redesign. The largest absolute gap was for Delivery System Design, although Minnesota’s score (73.6) was still well above the national average (60.8), suggesting challenges across regions.

Table 2: Practice Assessment Results: Minnesota (n=24 practices)

Survey Dimension and Scale	National Mean	Minnesota Mean
1. First contact: Access (1-4)	3.20	3.36
2. Ongoing care (1-4)	3.48	3.34 [†]
3. Coordination (1-4)	3.39	3.31 [†]
4. Comprehensiveness: Services Available (1-4)	3.74	3.82
5. Comprehensiveness: Services Provided (1-4)	3.69	3.69
6. Family-centeredness (1-4)	3.66	3.68
7. Community orientation (1-4)	3.06	3.21
8. Culturally competent (1-4)	3.44	3.81
9. Leadership (1-5)	4.00	4.15
10. Health System (0-100)	64.4	92.3
11. Delivery System Redesign (0-100)	60.8	73.6 [^]
12. Clinical Information Systems (0-100)	79.3	91.1
13. Decision Support (0-100)	74.8	91.2

[†]Denotes score below the national mean.

[^]Denotes regional mean more than 25% from highest achievable score.

Barriers and Facilitators. The survey asked about barriers and facilitators for providing optimal primary care and implementing quality improvement initiatives. Minnesota practices identified three resources needed to ensure appropriate primary care services: assistance with implementing quality improvement processes (23%), HIT systems

(19%), and administrative senior leadership support (19%). One practice wanted more “buy-in of the physicians,” noting “pressures for productivity, quality measures, forms, etc. It is hard to free them up enough to turn their attention to strategizing for quality improvement.” Another said: “Meaningful payment reform is critical to... improving health disparities, [as is] focusing on prevention rather than treatment.”

Respondents also identified financial resources (77%), educational support (54%), a practice coach/facilitator (38%), and technological resources (35%) as necessary facilitators to bridge gaps in providing quality care. They believe that these resources should come from:

- Other purchasers, such as employers, Medicare (62%)
- Parent organization (54%)
- Medicaid agency (54%)
- A quality improvement organization (35%)
- Regulators (23%)

Expanding upon the above, respondents noted the following as necessary to facilitate quality improvements: 1) “Implementing all of the evidence-based strategies, sharing outcome data with physicians and staff and holding them more accountable for outcomes;” and 2) “Hiring additional staff.”

Quality Incentives. In Minnesota, 11 practices (42%) receive reimbursement for patient care management, another 11 (42%) do not, and four (15%) did not know whether they do. In contrast, only five practices (19%) are reimbursed for medical home participation, 14 (54%) are not, and seven (27%) did not know if they are.

Minnesota practices serving a large number of Medicaid-enrolled and uninsured patients receive financial incentives for the following:

- Improved patient outcomes (eight practices, 31%)
- Quality improvement activities participation (six practices, 23%)
- Implementing new technology (four practices, 15%)
- Processes of care (three practices, 12%)

Practice Characteristics that Correlate with Quality Indicators. CHCS conducted bivariate correlations among the 13 practice dimensions included in the practice assessment survey and the two optimal quality indicators provided by MNMC (see Table 3). This analysis found that higher scores on the Access, Coordination and Decision Support dimensions were associated with higher scores on both the optimal diabetes and optimal vascular quality indicators.

Table 3. Correlations between Survey Dimensions and Quality Indicators: Minnesota

Survey Dimension	Optimal Diabetes	Optimal Vascular
1. First contact: Access	.43**	.44**
2. Ongoing care	.39	.19
3. Coordination	.40*	.35*
4. Comprehensiveness: Services Available	-.12	-.09
5. Comprehensiveness: Services Provided	.18	.13
6. Family-centeredness	.24	.06
7. Community orientation	.31	.26
8. Culturally competent	.12	-.04
9. Leadership	.26	.23
10. Health System	.34	.28
11. Delivery System Redesign	.29	.17
12. Clinical Information Systems	.14	.11
13. Decision Support	.38*	.41**

*p<.10, **p<.05

CONCLUSIONS

Overall survey findings reveal that high-value primary care practices in Minnesota are performing better than the national average on most practice dimensions. However, opportunities for improvement exist in Ongoing Care, Coordination, and Delivery System Redesign. Given that Coordination is one of three dimensions found to be significantly associated with quality of care measures, practice-level investments or quality improvement support directed at this dimension could yield marked improvements in both diabetes and vascular care.

Though regional scores on Access and Decision Support – the two other dimensions found to be significantly associated with quality of care -- were relatively high,

opportunities exist in those areas, as well. For example, outreach and resources could be directed to individual practices with relatively lower scores on these dimensions.

Another opportunity is apparent around quality-based financial incentives: a low percentage of practices receive reimbursement for care management or for medical home participation (42% and 19%, respectively), and a meaningful percentage were unsure whether they do (15% and 27%, respectively). These findings suggest the need to raise awareness about the availability of quality incentives, as well as opportunities to use these incentives to better align payment with practice transformation.

In sum, the findings of this study can help to drive provider education and practice site improvement opportunities to optimally target and transform high-value primary care practices. Identifying the practice capacities and characteristics that are in most need of quality improvement support – and may have the greatest impact on care delivery -- is a critical first step. These efforts can help to develop a better primary care system for the current 60 million and soon-to-be 80 million people nationwide served by Medicaid.

ⁱ Developed by Barbara Starfield and colleagues at The Johns Hopkins Primary Care Policy Center, Johns Hopkins Bloomberg School of Public Health. For more information, visit: http://www.jhsph.edu/pcpc/pca_tools.html.

ⁱⁱ Developed and owned by the NCQA. L.I. Solberg, S.E. Asche, L.G. Pawlson, S.H. Scholle and S.C. Shih. “Practice Systems are Associated with High-quality Care for Diabetes,” *The American Journal of Managed Care*, 14, No. 2 (2008): 85-92.

ⁱⁱⁱ P.A. Nutting, L.W. Miller, B.F. Crabtree, C.R. Jaén, E.E. Stewart, and K.C. Strange. “Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home,” *Annals of Family Medicine*, 2009: 254-260.

Appendix A: Participating Practices

- ACMC-Wilmar Main Clinic
- Bloomington Lake Clinic - Lake Street Clinic
- Community-University Health Care Center
- Fairview Health Services
 - Fridley Clinic
 - Lakeville Clinic
 - Red Wing Clinic / Zumbrota
- Fremont Community Health Services
 - Central Clinic
 - Fremont Clinic
- HealthEast Care System
 - Rice Street Clinic
 - Roselawn Clinic
- HealthPartners
 - Brooklyn Center Clinic
 - Center for International Health
 - HealthPartners Specialty Center
 - Midway Clinic
 - Riverside Clinic
- Hennepin Faculty Associates (HFA)
 - HCMC Family Medicine
 - Hennepin Care North
 - Hennepin Care South
 - Hennepin Family Care
 - HFA Internal Medicine
- MeritCare Health System
 - Bemidji Clinic North
- Renville County Hospital and Clinics
 - Olivia Clinic
 - Renville Clinic
- St. Mary's/Duluth Clinic Health System - Hayward Clinic
- University of Minnesota Physicians
 - Bethesda Clinic
 - Broadway Family Medicine Clinic
 - Smiley's Family Medicine Clinic

Appendix B: Characteristics of Responding Practices

Respondents could select more than one answer to each of the following; therefore percentages do not total 100%. Unless noted, all 26 practices provided responses.

Role of survey respondent

- Medical Director / CMO (13 practices, 50%)
- Clinic Director / Manager (8 practices, 31%)
- QI Director / Manager (2 practices, 8%)
- President / Executive Director (1 practice, 4%)
- Finance Director / Manager (1 practice, 4%)
- Office Manager (1 practice, 4%)
- Other (1 practice, 4%)

Type of facility

- Multi-specialty group facility (15 practices, 63%)
- Community / neighborhood health clinic (5 practices, 21%)
- Hospital clinic (5 practices, 21%)
- Single specialty group facility (4 practices, 15%)
- Rural health clinic (1 practice, 4%)
- Solo facility (1 practice, 4%)
- Other (2 practice, 8%)

Practice focus

- General practice/family medicine (10 practices, 39%)
- Combination of primary care subspecialties (7 practices, 27%)
- Combination of general practice/family medicine and general internal medicine/pediatrics (6 practices, 23%)
- Primary care (3 practices, 11%)

Reimbursement

Patient health plans (mean response, n=24)

- Private (32%)
- Medicaid (32%)
- Medicare (22%)
- Uninsured (13%)
- Other (2%)

Reimbursement type (mean response)

- Fee-for-service (56%, n=19)
- Capitation (15%, n=18)
- Direct payment (13%, n=18)
- Other (5%, n=17)