

SUPPORTING SMALL PRACTICES

Lessons
for
Health
Reform

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NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) is the most-used and most-recognized performance measurement tool in health care. NCQA accredits and certifies a wide range of health care organizations and recognizes physicians in key clinical areas. NCQA is committed to providing health care quality information that helps consumers, employers and others make more informed health care choices. Forty states and the Federal government use NCQA programs or HEDIS to supplement their regulatory efforts, and NCQA collaborates with *U.S. News & World Report* to recognize *America's Best Health Insurance Plans*.

SUMMARY

SMALL MEDICAL PRACTICES PLAY AN IMPORTANT ROLE in the care of patients with diverse needs. These practices often have limited infrastructure and face significant barriers to providing the highest quality health care. If small practices are to provide accessible, effective and efficient care for vulnerable patients, they will need additional attention, resources and support. Given the proportion of care these practices provide, especially in underserved urban and rural areas, failure to provide adequate help in adapting to the new demands for health information technology, quality and accountability could greatly impair the chances for successful health care reform.

To understand the needs of small practices in providing the best quality care, the National Committee for Quality Assurance (NCQA) launched a quality improvement demonstration program for small physician practices serving minority populations. With funding from The California Endowment, NCQA provided grants and technical assistance to small practices (5 physicians or fewer). The goal of the project was to learn what types of resources and tools these practices need in order to conduct and sustain quality improvement activities, especially for serving disadvantaged populations.

This project identified the specific challenges and needs of these practices. There was a strong interest in direct, practical assistance for meeting the needs of diverse populations. These small practices need and want close and ongoing support, technical assistance and shared resources including:

- Training and development for physicians as well as other clinical and non-clinical staff on topics such as
 - patient engagement skills and cultural competence;
 - language needs, including how to use telephone and in-person interpreters, and training for bilingual staff on interpreter roles;
 - quality improvement, including initiating, sustaining and evaluating successful changes to clinical practice; and
 - teamwork, including roles, responsibilities and staff development opportunities.
- Tools, templates and information resources such as
 - patient education materials in various languages;
 - clinical practice guidelines and other evidence-based medicine tools;
 - templates for organizing medical charts (care plans, problem lists, reminder tools); and
 - quality improvement tools.
- Shared services or staff to support
 - interpreter needs;
 - patient education or care management;
 - data analysis; and
 - Health Information Technology maintenance and technical support.
- Networking opportunities and learning collaboratives to hear from other practices, stakeholders, and local, state and national policy makers.



“WHEN WE STARTED THIS PROJECT, IT REALLY BROUGHT TO LIGHT THE LIMITATIONS WE EXPERIENCE AS A SOLO PRACTICE. LIMITATIONS IN OUR RESOURCES, LIMITATIONS IN ACCESS TO TECHNOLOGY BECAUSE OF THOSE RESOURCES, LIMITATIONS IN LEAN-UPON SUPPORT FROM GROUPS ... ADMINISTRATIVE STAFF ... PERSONNEL STAFF ...”

A model for policymakers to consider for addressing these needs is the recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act. This act provides for standardized definitions and measures of meaningful use that will help practices take advantage of the potential benefits of electronic health records and also includes a provision to create regional technical assistance programs to support the implementation and meaningful use of health information technology (HIT). If these resource centers are to be successful in helping practices achieve the benefits of HIT, they will also need to address the other major barriers facing small practices related to organizing their practices to support quality improvement and meeting the needs of diverse populations. To really transform the delivery of health care, it is likely that additional funding, beyond what is available in HITECH, will be needed so that these centers can provide the trainings, tools, services and collaborative opportunities that small practices want and need.

ABOUT THE PROJECT

NCQA worked with local partners, the California Medical

Association Foundation in California and Health

Care Quality Solutions, Inc. in New Jersey, to identify

volunteer primary care practices for the project. Each

practice designated a physician and an office staff

member to participate in the quality improvement activity.

Twenty-two practices were nominated and 19 were able

to complete the project. To be eligible for the project,

practices were required to be independent and serve

adult patients. In addition, they were required to have:

- five or fewer physicians;
- at least one-quarter of all patients served by the practice being from one or more racial/ethnic minority groups;
- a basic capacity to identify patients by characteristics or clinical condition; and
- little or no prior experience with quality improvement methods.

This set of characteristics helped NCQA learn what was

needed to support practices with the least experience

with quality improvement and electronic health records,

like most small practices in the United States today.

Each practice selected a health area on which to work

that was important to patients in their practice and

received up to \$25,000 to help defray the cost of

participating in the project. Most practices chose to

use this to purchase health information technology.

SUPPORTING SMALL PRACTICES: Lessons for Health Reform

HEALTH CARE REFORM AND SMALL PRACTICES

President Obama has made health care reform — addressing the need to improve access, affordability and quality — a key priority for the 111th Congress. Recent legislation and health reform proposals highlight the need for improving the quality of care and creating state-of-the-art, sustainable models of care. As we move to increasing health care providers' accountability for quality and costs of care, it is important to consider the impact on small practices, especially those serving diverse and disadvantaged populations.

Small practices in particular play an important role in our communities. Small, independently owned practices with 5 physicians or fewer provide nearly three-quarters of all ambulatory care visits.¹ While national data on the role of small practices in serving disadvantaged populations is not currently available, it is clear that small practices are critical to serving low-income, ethnically and linguistically diverse populations, especially in inner city or remote rural communities. For example, in 2008, about half of all Medicaid beneficiaries in Arkansas, Michigan and Southwest Pennsylvania were served by practices with three or fewer providers.² In Michigan, 55 percent of African-American Medicaid beneficiaries received care in practices with three or fewer providers. Many of the major challenges to the effective and efficient functioning of our health care system reside in these populations.



"WE KNOW EVERYBODY. OUR PATIENTS THAT COME IN ARE ON A FIRST-NAME BASIS. EVEN IF A NEW PATIENT

WERE TO COME IN TODAY, WHEN THEY COME BACK IN A MONTH, WE KNOW THEM."

UNDERSTANDING WHAT SMALL PRACTICES NEED

To understand what it takes to help small practices provide the best quality care, the National Committee for Quality Assurance (NCQA) launched a demonstration program for small physician practices. This program was designed to support small practices serving minority populations to conduct projects intended to improve the quality of care. With funding from The California Endowment, NCQA provided both grants and technical assistance through national experts and locally-based project partners. The main goal was to learn what types of resources and tools small practices need in order to conduct and sustain quality improvement activities to meet the needs of diverse populations.

KEY ISSUES FOR PRACTICES

Despite a deep dedication to the welfare of their patients, these practices faced significant barriers to providing high quality care, including the challenges of serving their diverse populations and the requisite knowledge and skills for measuring and improving quality, building a team and implementing HIT.

Serving a diverse population

Participating practices often confronted problems serving their diverse patient populations, particularly in addressing language needs and adherence issues. Practice staff and physicians reported that they felt ill-prepared to address the language needs of their patients. They noted particular difficulties providing telephone advice to patients who speak other languages, and less than half of the practices reported feeling comfortable working with a medical interpreter. Several physicians also said they were unable to afford interpreter services for their patients and were uncomfortable paying for the services for fear that they would not be reimbursed by insurance companies.



“THAT’S PART OF THE ISSUE OF DEALING WITH DIVERSE POPULATIONS. THEY’RE MORE DIFFICULT ... THEY TAKE MORE TIME, YOU’VE GOT TO DO IT IN THEIR LANGUAGE, YOU’VE GOT TO ADJUST CULTURALLY FOR THEM AND AT THE SAME TIME, THE REIMBURSEMENT IS THE SAME AS ANYBODY ELSE, WHETHER YOU TOOK FIVE MINUTES WITH THEM OR YOU TOOK 15 MINUTES WITH THEM.”

Along with language barriers, patient adherence to medical advice and treatment instructions was also a significant problem. While this is a problem for most practicing physicians, the majority of the small practices felt that social and environmental challenges that prevent patients from adhering to recommendations were a larger problem. For instance, a practice working to increase smoking cessation among its patients found that many of the patients could not afford a full dose of nicotine replacement therapy at one time and were therefore unable to comply with the recommended treatment. Physicians also noted that payment mechanisms do not consider the additional time and costs associated with addressing the communication and adherence issues common in their patients.

Practice staff valued the training in cultural competence and communication skills they received as part of the project to deal with some of these issues. Physicians and staff reported increased awareness of the different cultures and customs of their patients and how they might affect communication and quality of patient care.

Improving Quality

All of the practices needed significant amounts of technical assistance to implement basic quality improvement processes. The language and tools of quality improvement, measurement and population management were largely unfamiliar to physicians and staff and challenging to learn. Practices were eager to use new techniques to increase

screening and adherence rates and tools for organizing patient information (such as forms for tracking problems, medications and preventive care). However, many of the practices were isolated from other practices and health care organizations and unaware of such tools and procedures. In other cases, practices were unable to analyze and track even basic data on their patients over time. Even after implementing electronic systems, practices needed help to learn how to use this information effectively. It was also difficult for small practices to stay current with clinical practice guidelines and standards that are constantly changing.

Despite the challenges of lack of time, resources and training, practice staff are eager to learn how to improve quality of care for their patients, especially in ways that are feasible for small practices.

Building an Effective Health Care Team

Small practices often cannot attract or afford specialized staff that larger practices may have. Many staff members in small practices therefore serve in multiple roles, often juggling the duties of language interpreter, billing clerk, medical assistant and office manager simultaneously. These staff members can be integral to how the practice functions, and quality cannot be improved without their participation. At the same time, however, they are often stretched too thin and overburdened with administrative tasks. In many practices, there was little or no knowledge of the most effective ways to utilize staff resources to provide the full spectrum of services required by patients, nor the training for existing staff in more effective use of their skills.

In many small practices, there is significant staff turnover. Hiring and training can be time-consuming and expensive. In most instances, staff with limited experience conducting quality improvement ended up being an integral part of the practice’s project, spending more time with patients, learning to collect and track data and working more closely with physicians to improve care.



"THERE IS NOBODY IN OUR INDUSTRY THAT ASKS US THE QUESTIONS THAT YOU ASKED. THERE WAS NOBODY INTERESTED IN OUR IMPROVEMENT OF QUALITY OF CARE TO MINORITIES UNTIL YOU CAME ALONG ... WE WANT YOU TO STIMULATE US. WE HAVE LOTS OF IDEAS."

Both physicians and practice staff responded positively to involving non-clinical and other clinical staff in quality improvement training and activities. Staff credited participation in the quality improvement project with improving communication between the doctor and staff and increasing the roles and responsibilities of non-physicians. Physicians reported enhanced enthusiasm and reduced turnover of staff.

Implementing Electronic Medical Records

A fully-functional electronic medical record (EMR) that is interoperable and includes critical registry, analysis and retrieval functions could go a long way to addressing some of the issues the practices encountered when trying to improve quality. In particular, EMRs might address concerns such as having easy access to information about individual patients and being able to identify all patients in the practice with particular health problems. Practices without EMRs often had to develop time consuming processes to get needed information.

Many of the practices could easily see the value of using an EMR and were interested in doing so. By the end of the project, however, only five practices had an EMR that was functioning and six were still in the process of implementation. Three of the practices decided to purchase a disease registry rather than an EMR after deciding that the costs and complexities of EMR implementation were beyond their capacity. Finally, two practices decided not to implement any computer-based system due to concerns about finances, staff time and lack of expertise.

Once an EMR was installed, the practices still had considerable challenges to overcome. This ranged from lacking the computer expertise to get the software fully up and running to having office staff and medical assistants who lacked basic computer and keyboard skills. System upkeep and trouble-shooting also became extremely problematic for some practices, causing great frustration. Many physicians spent evenings and weekends implementing new HIT. Receiving ongoing training and technical support also proved frustrating to some practices that often had to pay the vendors additional hourly fees for training or trouble-shooting.

In addition, there was lack of understanding among the practices, and from the vendors with whom they worked, about what was involved in making the EMR a useful tool. Some practices had not evaluated the capacity to produce usable reports about multiple patients when initially selecting their EMR—for example, being able to generate a list of all patients affected by a drug recall or the average level of cholesterol tests for heart patients. Once installed, practices faced challenges obtaining useful reports or linking important data resources like laboratory results. Several practices reported that laboratory services refused to make the connections to allow them to link to laboratory results or that it was too expensive to do so.

National agreement among stakeholders on desired functionalities and reports, i.e. meaningful uses, from EHRs can address this shortcoming of many current EHRs.



"I SPENT A HUGE AMOUNT OF TIME SELECTING THE RIGHT EMR. THE NUMBER OF DIFFERENT EMRS WITH DIFFERENT FEATURES, SUPPORT OPTIONS, AND THE WIDE RANGE OF COSTS MADE IT VERY DIFFICULT TO COMPARE AND SELECT THE RIGHT EMR FOR MY PRACTICE. EVEN ONCE THIS WAS DONE, I SPENT HOURS CRAWLING AROUND THE FLOOR OF MY OFFICE ON THE WEEKENDS TO INSTALL THE WIRING WE NEEDED. THERE WAS NO ONE ELSE WHO COULD DO THIS, AND EVEN WITH THE GRANT MONEY I COULDN'T AFFORD TO HIRE SOMEONE TO HELP."

THE COMMITMENT OF SMALL PRACTICES

Both as small businesses and as health care providers, this group of practices is extraordinarily committed to the communities they serve. This takes many forms and can include significant financial costs to the practices. For example, a California physician paid out-of-pocket for tests to measure long-term blood sugar control for his diabetic patients. Though there is a lab test that is FDA-approved for use in his office, the insurance company would not cover this service because it maintains a capitated contract with the lab. But many patients would not go to the lab to have the test done. This created the additional challenge of having to track the patients down to make sure they went to the lab and bringing them back into the office to talk about their results.

"Providing this test in my office lets me talk immediately with patients about the results, and then we can make a decision together about their care. It helps my patients have better control over their diabetes."

SUPPORTING SMALL PRACTICES

Physicians in participating small practices expressed the desire for ongoing technical assistance, shared resources and networking opportunities. Examples include:

- Training and development for physicians as well as other clinical and non-clinical staff on topics such as
 - patient engagement skills and cultural competence;
 - language needs, including how to use telephone and in-person interpreters and training for bilingual staff on interpreter roles;
 - quality improvement, including initiating, sustaining and evaluating successful changes to clinical practice; and
 - teamwork, including roles, responsibilities and staff development opportunities.
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 - quality improvement tools.
- Shared services or staff to support
 - interpreter needs;
 - patient education or care management;
 - data analysis; and
 - HIT maintenance and technical support.
- Networking opportunities and learning collaboratives to hear from other practices, stakeholders and local, state and national policy makers.

Busy small practice physicians are eager for assistance that allows quick successes with manageable cost and time investments on their part. They need shared turnkey applications and packages of tools that are already developed and ready for easy implementation.

IMPLICATIONS FOR HEALTH CARE REFORM

President Obama and leaders in Congress have made strong commitments to passing legislation that will significantly reform the health care system with new accountabilities for quality and costs of care. The Health Information Technology for Economic and Clinical Health (HITECH) Act provides for regional technical assistance programs to support the implementation and meaningful use of health information technology. The regional centers give priority to certain types of providers, including individual or small group practices focused on primary care and providers that serve uninsured, underinsured and medically underserved individuals.

The HITECH Extension Program could serve as a model for supporting the needs of small practices in serving diverse populations. Such entities allow for one-on-one support and training for continuous quality improvement at the small practice level, as well as shared databases, tools and other resources to support small practice physicians and staff. A national process for defining and measuring meaningful use for EHR users, as provided for in HITECH, can also address some of the shortcomings of current EHRs experienced by practices.

CONCLUSION

Small practices are not just smaller-scale versions of large practices but differ in fundamental ways. Many of them lack the infrastructure, trained staff and other resources to independently embark on projects to improve the quality of care they provide, implement electronic health records, fully use their resources, and provide career development opportunities that will help keep staff engaged and reduce turnover. Given the substantial amount of health care they provide in the U.S., small medical practices will continue to play a crucial role in delivering health care to the U.S. population. Our research shows that small practices are willing to change and adapt their practices to best meet their patients' needs. However, in order to successfully encourage these practices to be more accountable, to improve quality and to reduce disparities, they will need significant support. This includes the provision of "hands-on" assistance and shared resources, as well as financing that recognizes the importance of services not adequately reimbursed through current fee-for-service payments. Finally, it will be crucial that reform efforts account for the lack of infrastructure and staff that may limit small practices' ability to readily undertake major improvement and reform activities. HITECH provisions for regional assistance centers and for standardized measures of meaningful use represent important progress. Health reform offers the opportunity to further support these kinds of assistance. This project suggests that such support is essential to achieving the objectives of health care reform.

¹ Cherry DK, Hing E, Woodwell DA, Rechtsteiner EA. *National Ambulatory Medical Care Survey: 2006 Summary*. National health statistics reports; no 3. Hyattsville, MD: National Center for Health Statistics. 2008.

² Center for Health Care Strategies, Inc. *Reducing Disparities at the Practice Site Fact Sheet*. Available at http://www.chcs.org/usr_doc/RDPS_Fact_Sheet.pdf. Accessed on June 3, 2009.



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