STATE QUALITY IMPROVEMENT INSTITUTE
EMAIL UPDATES
APRIL 2010

WASHINGTON

DESCRIBE THE LATEST PROGRESS YOUR STATE TEAM HAS MADE IN ITS QUALITY IMPROVEMENT EFFORTS.

Washington's Quality Institute team efforts continue to be concentrated in the three areas set out in our original proposal: Expanding patient-centered medical homes, developing payment strategies to support medical homes, and developing communication strategies for engaging consumers. Since our last update there has been activity in all three areas, notably in consumer engagement as that component of the reimbursement model pilot has ramped up.

Expand patient-centered medical homes

The Washington Patient-Centered Medical Home Collaborative, jointly sponsored by the Washington State Department of Health and Washington Academy of Family Physicians, has taken several steps to make practice transformation operational for its participating providers.

- Thirty three primary care practice teams of 3 or more staff participated in Learning Session 2, Mar 29-30, 2010, of the Washington Patient-Centered Medical Home Collaborative. Patient centeredness and teamwork themes guided the curriculum for the 250 participants. The agenda is attached. The teams meet together to share learnings three more times during the Collaborative process.

- The Learning Session hosted Richard Onizuka discussing the Multi-Payer Medical Home Reimbursement Pilot. Engaged discussion led several practices to volunteer to meet individually with Richard to explore the reimbursement pilot further. The Collaborative teams exhibit varying interest in the reimbursement pilot process.

- The potential cost savings literature for implementing a medical home, highlights essential element of care coordination. Teams were introduced to this literature at Learning Session 2. The importance of saving health care costs through unnecessary emergency room visits, avoidable hospitalizations and repeat hospitalizations will direct future team presentations.

- Jan Norman presented the work of the Collaborative to the SW Hospital Council on April 15, 2010. With 5 of the 33 practices admitting to hospitals in the Council, it presented an opportunity to ask for their support to work on care coordination with the teams. Two of the seven CEO's responded favorably. The remainder viewed care coordination as reducing their revenue sources.

Develop payment strategies to support medical homes
Building on its earlier work, the planning group for the Multipayer Reimbursement Model Pilot project has taken the following actions:

- The Aligning Incentives Workgroup continues work on developing one or more reimbursement models for presentation to the Participant Group. The basic components of the models under consideration remain as they have been since the beginning of deliberations: various combinations of fee-for-service (FFS) for clinical procedures, capitated care management fees and performance/quality incentives.

  We have continued to take advantage of the expertise of Harold Miller of the Network for Regional Health Improvement. Mr. Miller has presented simulations of the two models mentioned in the last update, which built on the workgroup's previous work and sought to address some of the unresolved concerns of both payers and providers. These models include the original elements of FFS for clinical procedures, a per member per month (PMPM) care management fee, and incentives for achieving cost/utilization and clinical quality objectives. The primary difference between the two is that in "Plan A" the practice transformation investment is made by the participating practice, with no constraints on the interventions used nor performance targets while in "Plan E" the initial investment is made by the payer and provider jointly, with specific utilization targets for eligibility to avoid financial penalties and receive incentive payment. Mr. Miller is currently developing a simulation reflecting the most recent thinking about Plan E for presentation and discussion at the April 27 meeting of the full Participant Group.

- The Measurement and Evaluation workgroup presented its recommendations to the Participant Group, with the observation that evaluation criteria should not be prescriptive of the overall pilot design but rather should be adapted to the project design that meets other pilot needs most effectively. An optimal evaluation plan would include a minimum of 16 investigation practices for each reimbursement model and 16 matching controls. The Participant Group and Aligning Incentives Workgroup have taken these recommendations into consideration in regard to the overall scale of the pilot.

- The Consumer Engagement Workgroup has also presented its recommendations to the Participant Group. These include:

  - Creating a consumer engagement toolkit for all practices participating in the pilot;
  - Providing all consumers with contact information to support coordinated care;
  - Developing care plans between patients and their health care teams;
  - Using patient/family feedback for practice development and continuous improvement; and

    - Ensuring links with relevant community based resources.
- As noted above, Richard Onizuka's presentation to the PCMH Collaborative's Second Learning Session triggered the desire on some participating practices for additional information. As a follow-up, interviews were held with senior management of nine volunteer practices to explore the current models in greater depth and get their reaction. The responses are summarized in the attached "Practice Feedback" document, and illustrate the questions these practices have about several elements of the pilot, most of which have not yet been finalized.

At present there remain a number of decision points to be resolved, some of which are discussed at 3 below.

SINCE THE LAST EMAIL UPDATE, HAS YOUR STATE ENCOUNTERED ANYTHING UNANTICIPATED, OR HAS SOMETHING SIGNIFICANTLY CHANGED FROM WHAT IS OUTLINED IN YOUR CURRENT ACTION PLAN? IF SO, PLEASE DESCRIBE.

As reported previously, Participant Group for the reimbursement model pilot had extended the time span from the originally planned 18 months to two years, with a possible extensions for a third year. The model simulations presented by Harold Miller assume a 3-year initial cycle for the pilot in order to allow for capture and analysis of the first-year results and incorporation into practice interventions with a long enough time period to achieve results. At its March meeting the Participant Group agreed to the three-year timeframe and planning is now being made on that basis.

Another important development emerging was the informal working agreement that the pilot should more properly be viewed as a research and development (R & D) exercise than as an investment-based business proposition. Viewed from this perspective the payer's commitment under any given model is a more straightforward proposition than if all the variables potentially affecting a business enterprise must be considered.

A third emerging element is the awareness that the clinical drivers of high utilization are different in the commercially insured population from those of the Medicare population. While the latter predominantly display chronic physical conditions like diabetes and cardiovascular disease, the former are more likely to have behavioral or substance abuse co-morbidities.

WHAT HAS YOUR STATE TEAM BEEN CHALLENGED BY DURING THIS PROCESS?

For the multi-payer reimbursement model pilot an ongoing challenge, previously mentioned, continues to be determining the scale of the project. Even in the context of the pilot as an R & D exercise, payers' and providers' willingness to accept risk, even controlled, will be central to deciding how many practices, and of what size, will be invited to participate, particularly under some variant of Plan E, which involves payer support of the original investment. At the same time, the reimbursement options available to medical practices will influence how many, and which ones, choose to participate based on the degree of risk they are able and willing to accept.

In this context it is important to note the asymmetry of the risk involved. For the payer, the exposure is limited to its commercial business, for the small number of participating providers, for the 3-year term of the pilot. For the practice, on the other hand, it's potentially as much as 60% of its revenue stream for the same period, enough to threaten its continued existence.

This general area of risk encompasses a number of sub-issues—inexactness and un-timeliness of utilization data, ambiguity about which interventions are truly effective, concerns about how patients will be attributed to a practice and how to manage both adverse selection and high-cost outliers, and other similar concerns.

The Aligning Incentives Workgroup and larger Participant Group have started focusing on how these kinds of questions drive which practices should be invited to participate. Is there a minimum practice size that can be successful at carrying out and supporting practice transformation? Is there a "sweet spot" in the continuum of Medical Home readiness that can potentially produce the maximum improvement in performance? Is the high-performing practice that has already made a substantial investment in practice transformation, and has relatively less margin for improvement, a good candidate to participate?

These are some of the kinds of issues and questions that will confront the Participant Group as we move forward, but resolving them will provide valuable resources to those who want to build on our experience.