

**STATE QUALITY IMPROVEMENT INSTITUTE  
EMAIL UPDATES  
FEBRUARY 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. Activity is concentrated primarily in the first two of these areas, but as noted below there has also been activity in consumer engagement within the area of developing reimbursement strategies.

*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:

- Leadership from the Collaborative participated in the Practice Transformation Workgroup of the Multi-Payer Medical Home Reimbursement Model Project. Recommendations on the outcomes, core practice competencies and pilot practices were submitted to the workgroup in November 2009.
- Collaborative funding to complete the baseline data on patient experience has tentatively been located. DOH plans to conduct a survey of 100 patients per practice in the first quarter of 2010. DOH will be conducting the patient experience survey in March 2010 using a CG-CAHPS-like survey tool. An IRB review determined the survey effort to be exempt. Clinics will provide DOH with a list of 100 randomly selected patients for a two-wave mail survey.
- Coaches and staff meeting twice a month to coordinate site visits, hone consultative skills, and develop the curriculum for the next Learning Session, March 29-30, 2010. There was a faculty planning meeting January 21, 2010 and a draft agenda for the learning session has been created.
- Webinars continue monthly. Topics covered include Collaborative measures (October); self-management support (November); and the diabetes reporting template for IPIP (December); Using EHR Information to Support Workflow for the medical home (January); Tobacco Assessment and Cessation (February); and Patient Experience Survey (March).

- Data Reporting on prevention measures began in January, with 25 of 33 practices reporting. Diabetes reporting, originally scheduled for January, was rescheduled for February 10 due to IPIP reporting template issues. Since the latter date, reports have been received from 11 clinics and are continuing to come in. We are assisting clinics with data quality and reporting issues, with the goal of having all clinics report the prevention measures by March. Each practice is required to report on the equivalent of 1 panel of patients from a full time provider.
- The DOH Patient-Centered Medical Home Collaborative progress report was submitted to the legislature December 31, 2009.

*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:

- As reported in the last update, the Aligning Incentives Workgroup is working on developing one or more reimbursement models for presentation to the Participant Group. Elements under consideration include various combinations of fee-for-service (FFS) for clinical procedures, care management fees and performance/quality incentives. With the support of SQII, the pilot has accessed the services of Michael Bailit of Bailit Health Purchasing, including telephone consultation and distribution within the group of documents prepared by Mr. Bailit for his consulting engagements. Mr. Bailit joined the workgroup and the full Participant Group for their meetings on January 7 to share his insights from the various state-level multi-payer pilots in which he has been involved. The full Participant Group discussed two models submitted for review by the workgroup and directed the workgroup to continue examining and developing reimbursement options that could address the needs of a range of providers and payers/purchasers in Washington.

Following meetings of subgroups of payers and providers, the workgroup again met February 19 with the assistance of Harold Miller, who had facilitated the October reimbursement summit. Mr. Miller presented two additional models for discussion, which built on the workgroup's previous work and sought to address some of the unresolved concerns of both payers and providers. From that discussion emerged two additional models, essentially hybrids of a workgroup model with each of Mr. Miller's models. These included 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. These two models are currently being further developed for presentation to the Participant Group in late March.

- With the pro bono consulting assistance of Point B, the Participant Group will continue to monitor progress against its project plan and timeline, revising and updating those instruments as the situation evolves. As noted below, one outcome of the Aligning Incentive Workgroup's recent work has been a movement toward

thinking of the pilot in terms of 3 years rather than two, although that potential change has not yet been formally addressed.

- As the work on reimbursement models has developed, it has become increasingly apparent that it can mutually impact both the evaluation model and consumer engagement efforts. Accordingly, new workgroups have been initiated in these two subject areas. Both held their first meetings in mid-February and will make their initial reports at the March Participant Group meeting.

**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, discussion within the Participant Group and input from consultants indicate that the originally planned 18-month operational period for the pilot may not be long enough to produce measurable results—particularly among practices which must go through major practice transformation to achieve the core competencies required. Thus the group had agreed to expand the operational period to two years, with the possibility of expanding for a third year.

In the Aligning Incentives Workgroup, the most recent discussions have been around variations of the reimbursement models developed by Harold Miller. These models seek to align payer and provider incentives by balancing risk and reward through an iterative process as improvements generate payoff over time. Thus they are designed with an initial structure spanning three years. The workgroup has not formally presented the idea of expanding the initial operating period of the pilot to three years, but may do so at the March meeting.

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

For the multipayer reimbursement model pilot an ongoing challenge, previously mentioned, is to determine the scale of the project. Payers' willingness to accept risk, even controlled, will be central to deciding how many practices, and of what size, will be invited to participate. 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 willing to accept.

Also as noted previously, questions have arisen about how pilot design can be modified to accommodate the needs/preferences of varying stakeholder groups. This, in turn, has raised questions about the level of methodological rigor to be sought in evaluation, the sample sizes and data quality required to achieve it and the capacity of providers, especially small or less "data savvy" practices, to provide the necessary data. Cumulatively, these questions in turn raise the higher-level question of what policy decisions need to be supported by the data generated by the pilot(s). This was part of the motivation to start the third workgroup in the area of data capture/analysis and project evaluation.

The discussions in the Aligning Incentives Workgroup and full Participant Group have also illuminated the important point that both payers and providers vary in their readiness to assume risk and to participate in certain models. There is no obvious “one size fits all” on either the payer or provider side of the relationship, so tailoring the model or models will require shaping it/them to a variety of needs.

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.