

**STATE QUALITY IMPROVEMENT INSTITUTE  
WASHINGTON UPDATE  
OCTOBER 2009**

**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 continues to be focused primarily in the first two of these areas.

**a. 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.

1. The collaborative held its first Learning Session for 33 primary care practices on September 29-30, 2009. This first face-to-face meeting (agenda and change package attached) focused on the teamwork and patient centered care as supported by the change package that will guide this 2 year collaborative. Over 240 people attended the Learning Session with between 3 and 8 staff from each clinic. Participating clinics received a stipend of \$1600 per Learning Session to assist with attendance costs and lost revenue from being out of the office.
1. Coaches assigned to each practice assist with its internal changes, ensure understanding of the reporting process, connect the practices to resources and trouble shoot problems that can impede their practices changes. Coaches meet monthly among themselves to develop their skills, learn from each other and plan their next site visits to the practices. Site visits ensure the teams are receiving one-on-one assistance and standardized communication.
2. Monthly telephone conference trainings for practices began in October 2009 addressing medical home concepts to supplement the Learning Session teachings.
3. Leadership from the Collaborative is participating in the Practice Transformation Workgroup of the Multi-Payer Medical Home Reimbursement Model Project. The evaluation design of the Collaborative has been shared with this work group.
4. The five part evaluation design for the Collaborative has been developed and implemented, including the following elements:
  - A. The degree of medical home principles implemented by the practice (First survey collected at Learning Session 1)
  - B. Changes in patient experience (Design still in process. See "Challenges" below.)
  - C. Changes in provider and staff satisfaction (First survey collected at Learning Session 1)
  - D. Changes in a set of clinical diabetes measure from the national Improving Performance in Practice (IPIP) project, and a set of prevention measures (First reports to be submitted January 2010)

- E. Changes in the utilization patterns and cost of patients enrolled in the Collaborative. (Design and completion dependent upon finding additional resources.)

### **b. 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:

1. Established and empowered two workgroups to develop the initial “pillars” of a medical home: practice transformation and aligning incentives of payers, providers and patients. These two workgroups are composed of members of the larger participant group (or their representatives) that has been meeting for approximately the past year to implement the legislatively mandated project.

Conceptually, the Practice Transformation workgroup’s task set precedes that of the Aligning Incentives workgroup, although in practice they have been working essentially concurrently, each having held two meetings at the time of writing. There is cross-participation at the leadership level of the two groups, with the Practice Transformation Workgroup’s recommendations helping inform the activities and decisions of the Aligning Incentives workgroup.

The initial deliverable from the workgroups’ efforts will be a limited “menu” of reimbursement models or options for discussion and broader stakeholder reaction at the reimbursement summit, to be led by Harold Miller, in Seattle on October 29.

The Practice Transformation workgroup has identified quantitative and qualitative performance improvement measures in the four domains of cost, utilization, clinical quality and patient experience, as well as an inventory of core capacities needed for primary care practices to achieve improvement in those measures. It has also developed recommendations with respect to the scope of the proposed pilots (targeted toward high-maintenance patients v. a provider’s entire panel) and criteria for provider readiness to participate in the pilot(s).

The Aligning Incentives workgroup has identified some common characteristics of provider reimbursement models, to inform decisions about what models/options to discuss at the reimbursement summit. At its October 20 meeting the workgroup identified three basic reimbursement models for consideration:

- a. Fee-for-service (FFS) for clinical services combined with a Care Management Services fee (perhaps per member per month (PMPM)) and pay-for-performance (P4P) incentive payment for reaching performance targets;
- b. Primary care capitation combined with P4P incentive payment. The range of services to be included in the capitation—from limited to comprehensive—would need to be determined; and

- c. Full-risk capitation for entities that can function as Accountable Care Organizations (ACO).

Of these three models, the first two will be discussed for broader stakeholder input at the reimbursement summit discussed below. The third will be discussed with the limited number of provider organizations likely to be interested in that option.

2. Planning for the October 29 reimbursement summit is approaching closure, with ongoing discussion about program design and reimbursement models to be discussed, how to frame the issues and options for discussion and expectations/deliverables for the event. A final planning meeting is scheduled for October 22.
3. Approximately 75 attendees are expected, including representation of providers, payers, self-funded purchasers and government agencies. The summit is cosponsored by the Puget Sound Health Alliance, Washington State Medical Association and Washington Academy of Family Physicians.
4. With the assistance of Plan B, a local consultancy providing pro bono services through the Puget Sound Health Alliance, the Participant Group reviewed a draft project plan and timeline, and will revisit the plan at its November meeting in the light of recommended changes in timing and components.
5. A draft letter for distribution to payers has been obtained from the Attorney General's office and distributed to payer representatives on the Participant Group for comment. This letter addresses potential payer concerns about antitrust exposure as a result of participating in a reimbursement pilot, with particular emphasis on the role of state action in providing the necessary protections.

**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 noted in the last report, there have been no completely unanticipated developments, but there have been useful learnings from the ongoing interactions among payers, providers and researchers. Recently-emerged examples that illustrate the challenge of aligning provider and payer incentives, as well as procedural challenges, are discussed at #3 below.

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

Because the state funding for the implementation and evaluation of the Washington Patient-Centered Medical Home Collaborative was eliminated by the budget reductions of the 2009 legislature, funds for the patient experience survey and cost/utilization study will need to be located from alternative funding sources. Staff and partners are seeking grants funds to complete these evaluation components.

Other potential challenges, identified earlier, are still being worked. One example is the difference between providers' and payers expectations regarding the timing for break-even on the investment to establish and implement medical home reimbursement. Payers are understandably interested in recovering their investment sooner rather than later, and thus may be more interested in initiatives that focus on high-maintenance patients; providers, on the other hand, are likely to be more interested in initiatives that can be implemented across their entire patient panels reducing operational disruption but probably resulting in slower achievement of breakeven.

A related potential issue is that of what exactly the project pays for. Payers have strongly indicated they are willing to pay for clinical improvement, particular when it results in reduced unnecessary cost and utilization. Providers, particularly those less "ready" for medical home services, will seek reimbursement for the front-end investment to achieve those clinical improvements.

In recent discussion of these concerns, related 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, 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). In that regard, a possible need has been identified to start a third workgroup in the area of data capture/analysis and project evaluation.

In the telephone consultation with Michael Bailit, one of the "four pillars" of medical homes to be discussed was consumer/patient engagement. Some of the design questions now emerging touch on this area, such as attribution v. formal enrollment of the consumer in the pilot. This, plus recent experience of some of the payers and providers involved in current projects, suggests the need to begin work in this area soon along with the practice transformation and incentives alignment activity currently going on.

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.