

IV. Project Narrative – Washington State

A. Description of the State Health Care Innovation Plan Testing Strategy

Washington (WA) is a *national leader* in containing costs and promoting high-quality health care. Innovations such as the “Generics First” prescription drug initiative and first-in-the-nation Health Technology Assessment program, both of which deliver and recommend safe, appropriate care for every dollar spent, have helped hold down the costs of the Medicaid program. We have created collaborative programs partnering the public and private sectors to improve health care quality and safety across the state. The Model will leverage our experience with the collaboratives to transform the service delivery system across the state and align payment with quality, evidence-based medicine.

With this grant, we propose to: 1) reform payment by shifting from traditional fee-for-service to new payment methods that provide incentives for professionals and facilities to work together to achieve higher value, lower cost care; 2) build on our state’s existing quality collaboratives, the [Bree Collaborative](#) (Bree) and the [Puget Sound Health Alliance](#) (Alliance), to convene multiple payers, providers and other organizations to develop transparent, evidence-based, quality and utilization metrics and evaluation criteria; and 3) start this effort by testing work the collaboratives have already initiated: obstetrics/deliveries; and managing chronic conditions. Over the three-year grant period, these interventions will affect up to one million Washingtonians and ninety thousand births.

Our vision for the future is to continue using the collaboratives and the strong evidence-based medicine foundation we have in WA to: 1) further the development and adoption of evidence-based practices; 2) develop robust and transparent metrics to turn data into information for payers and consumers; 3) fully implement quality payment reform; and 4) apply these reforms to other low-value, higher-cost treatments and episodes of care, such as mental health, oncology, cardiovascular, and orthopedics.

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The Model also addresses one of the thorniest questions in health care today: how can we develop integrated systems of care, (for example, Accountable Care Organizations, ACOs), in areas where providers and facilities work independently? Nationally, models such as [PROMETHEUS](#), [ProvenCare¹](#), [Group Health Cooperative](#) and [Blue Cross Blue Shield of Massachusetts](#) are called out in the literature as structures that align financial and clinical, professional and facility, and set budget and quality targets. However, these models largely assume that providers and facilities operate under the same organizational umbrella. To address this gap, the Model will bring together the state, employers, multiple payers, and providers under the existing collaboratives to test “virtual” or functional integration of services statewide. The scope of collaboration is striking – the state received nearly 80 letters of support, including purchasers (4 large corporations), government (11), payers (10), provider groups (18), professional (21) and partner/advocate organizations (15).

Developing functionally integrated care systems will require several components: 1) setting payer-specific budget targets, 2) gain sharing with professionals and facilities based on core quality and utilization metrics to provide incentive for best practices and contain costs; 3) sharing provider performance data to reduce variation; and 4) integrating systems by aligning accountability between the provider and facility. We will test the Model in two arenas: maternal/infant care and managing chronic care, using the Triple Aim² as our measure of success.

Q1: Model’s Purpose:

The Model’s purpose is to transform the health care system from one that all too often provides low-value, high-cost services to one that emphasizes evidence-based, quality care and that is responsive to consumers’ needs. The Model will deliver more high-value, lower cost services through several mechanisms:

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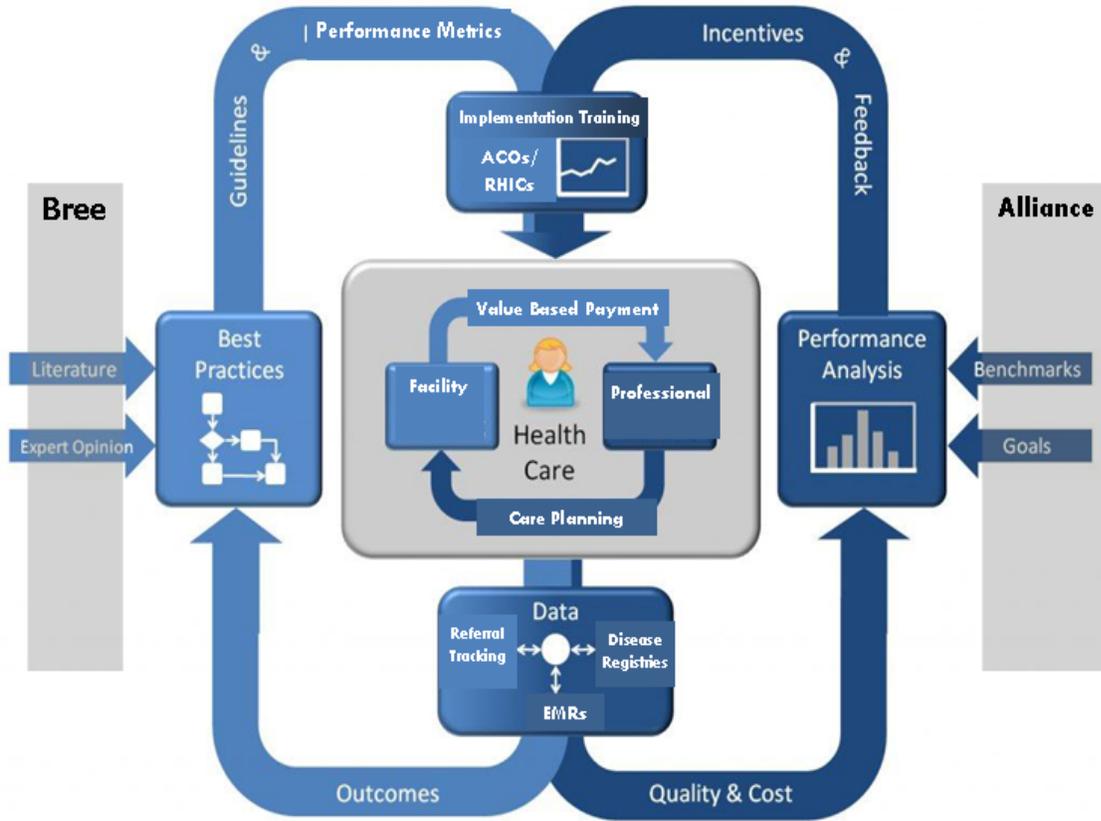
Emphasizing evidence-based services: the Model will build on the Bree’s efforts to: 1) identify high-cost, low-value episodes of care in local areas; 2) develop an empirically based set of recommendations on best practices for each episode of care; 3) modify payment methods with multiple payers to provide incentive for adoption of best practices; and 4) speed adoption through engagement of providers and payers, and Department of Health learning collaboratives.

Aggressive use of data: The Alliance will facilitate this effort through: 1) the adoption of a common set of evidence-based quality and utilization metrics; 2) data aggregation and improved reporting capabilities; and 3) increasing feedback loops to guide practitioners toward best practices. Quality program and processes proven to be effective by the [Foundation for Health Care Quality](#) (e.g., COAP or SCOAP) will be used across the system.

Collaborative engagement of multiple payers and providers: The Model will secure agreement among stakeholders on consistent approaches to transition from a volume-based, fee-for-service system toward a flexible system that ties payment to evidence-based, quality and utilization targets. This produces a win-win value proposition where payers have predictable expenditures and providers retain predictable revenues. This approach successfully accommodates a distributed delivery system through virtual integration of local service delivery.

Coordination with other initiatives: Last, the Model strategically aligns and adds value to existing federal and state initiatives, private/public partnerships, ACO, “virtual ACOs,” and regional health improvement collaborative (RHICs)³. Figure 1 illustrates the WA Model.⁴

Figure 1. Diagram of Washington Model



Q2: Scope of the Model

The scope of the Model will encompass most of the state’s health care system, including: state agency purchasers of health care services; private/commercial purchasers of health care services, such as Boeing and Costco; all significant payers; and all significant provider organizations and advocacy groups. The Model leverages two multi-payer statewide collaboratives charged with improving care: the Bree and Alliance. The two entities will work with the office of the Governor and the Health Care Authority (HCA) to support implementation of the Model. Initially, as proof of concept, the Bree will coordinate the obstetrics component of the Model, while the Alliance will coordinate the chronic conditions component of the Model. Their efforts are closely linked, and Steve Hill, former Director of the Health Care Authority and current board member of Leap Frog Initiative and Consumers Union, chairs them both. Each

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entity presents opportunities to link the professional and the facility through contracting and incentives to improve quality and better health outcomes. By targeting preventable high-cost facility care (for example, elective C-sections and re-hospitalizations), the Bree and Alliance will coordinate gain sharing opportunities between payers and providers.

The Robert Bree Collaborative (Bree) is a consortium of public and private agencies charged with identifying low-value, high-cost services to develop evidence-based best practice recommendations. Established by the WA legislature under [HB 1311](#), the Bree's scope encompasses the activities proposed in this application; however, if needed, the Senate and House Committee chairs agreed to sponsor legislation in the 2013 session to support an expanded role. Bree's membership is a cross-section of employers, including Boeing, Costco, Inland Northwest Health Services (Beacon grantee), King County, State of WA, health plans, and hospital and provider leaders, all appointed by the Governor. The Foundation for Health Care Quality (FHCQ), an independent, third party nonprofit that governs several large statewide performance measurement, safety, and health information initiatives, has been contracted to provide coordination, staff support and quality measurement programs for the Bree. FHCQ has received wide recognition for promoting surgical (SCOAP), obstetric (OB-COAP) and other checklists that reduce errors in care.

The Puget Sound Health Alliance (Alliance) is a private nonprofit founded in 2004. Its membership includes over 165 private and public health care stakeholders. Today, every payer in the state participates in the Alliance, as do many large employers, including Washington State, Starbucks, Boeing, Service Employees International Union (SEIU) and Alaska Air Group. The Alliance publishes the [Community Checkup](#) that publicly reports key quality measures of participating medical groups, clinics, hospitals and health plans in the Puget Sound region. The

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report serves as a resource to support quality decisions and improved patient care. With the State, the Alliance launched the [Patient Centered Medical Home Multi Payer Reimbursement Pilot](#), a project to develop, implement, and evaluate a different payment model for primary care, linking payment and the potential for shared savings to desired outcomes pursuant to [ESSB 5491](#) of 2009. It includes eight physician groups (with 12 clinic locations), approximately 27,500 patients, and seven payers: Premera, Regence, Aetna, Cigna, Community Health Plan of WA, Group Health Cooperative, and Molina.

We are using the term “Collaboratives” in this document to refer to both organizations.

Q3: Description of the delivery system or payment model(s) that will be tested

WA will implement both quality and payment reforms over the life of the project.

Principles: 1) There is increasing agreement on the need for accountability for quality and cost across the continuum of care. Consistent high-quality care, particularly for chronic conditions, will require coordination and engagement of multiple health care professionals across different institutional settings and specialties, including medical, behavioral, developmental disability, substance abuse, safety net providers, Area Agencies on Aging and long-term services, and support providers. 2) The reform must be viable across the diverse practice types and organizational settings that characterize the state’s health care system. But it also must be sufficiently flexible to allow for variation in the strategies that local health systems use to improve care. One size does not fit all. 3) The reform must shift the payment system from one that rewards volume and intensity to one that promotes value (higher value at lower cost). 4) The reform must provide greater transparency for consumers and community stakeholders. Measures of overall quality, cost and other aspects of performance will support the provider’s clinical decision-making and increase consumers’ confidence in their care.

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Description of Model:

A. The Washington Model will Align and Create Incentives for Improved Performance

Metrics Across Payers: The Collaboratives will engage facilities and professionals to link provider payment to an agreed-upon common core set of quality and utilization metrics. Initially, they will focus on the areas of obstetrics and managing chronic disease, aiming to increase use of evidence-based care and reduce overuse of low-value, high-cost services at the professional and facility levels. Payers' commitment to the Model is predicated on the flexibility to use their own contracting and payment mechanisms to provide incentive for common core quality outcomes and utilization targets. All payers have agreed to adopt a core set of performance measures and are willing to link those measures to opportunities for differential gain sharing (based on performance) and increase our current peer-to-peer comparisons to support improvement. The core quality and utilization metrics will be streamlined and aligned with CMS' [Physician Quality Reporting System \(PQRS\)](#), [National Quality Forum](#), [Joint Commission](#) and [Meaningful Use](#) and other nationally recognized incentive programs to avoid duplicative processes and improve administrative efficiencies. To that end, the Model has received full support from the three key agencies in the state: 1) Qualis Health, which serves as the state's Quality Improvement Organization (QIO) and operates the Regional Health Extension Center; 2) the State's Health Information Exchange, OneHealthPort; and 3) the federal Beacon Grant in Eastern WA.

B. The Washington Model Will Conduct Statewide Data Aggregation and Performance

Metrics Reporting: The Collaboratives will engage health care provider organizations, health insurers and self-funded purchasers to adopt consistent processes for data collection, monitoring cycles, and use of a core set of quality and utilization metrics to support statewide *Provider Feedback Reports* in obstetrics and management of chronic disease. Successful examples of such

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activities are currently active in WA, and address clinical conditions in obstetrics cardiology, general surgery, vascular surgery, spine surgery and obstetrics. As expansion of data volume grows, the Collaboratives will identify and work locally with outlier practices/processes and support access to local rapid cycle improvement processes. Hands-on coaching and peer learning opportunities will be provided by the State Department of Health in coordination with the WA State Medical Association, the WA State Hospital Association and the Foundation for Health Care Quality. Feedback will be publicly reported at the medical group or facility level, providing communities with a comprehensive picture of their local health care system. Publicly reported outcomes currently exist and will be enhanced with this grant.

C. The Washington Model Will Build Workforce Capacity to Promote Adoption of Evidence-Based Practice and Performance Metrics: Resources will be allocated to increase internal workforce capability to adopt evidence-based best practices in the areas of obstetrics and managing chronic disease. Financial grants will be directed to key professional organizations to champion initiatives among their membership. The Model will fund an expansion of the Department of Health’s [Collaborative Learning Model](#) to bring training to areas typically not seen as viable ACO venues. The Department of Health’s existing hands-on learning sessions will complement toolkits, “how-to” guides, checklists, and patient decision aids that support evidence-based recommendations. Structured stakeholder education, including conference calls, webinars and listservs, will provide practical insight to adapt recommendations to various settings. Recommendations will be incorporated into accredited continuing medical education programs and medical training programs with the support of the Department of Health.

D. The Washington Model Will Explore Policy Levers to Secure Adoption of Evidence-Based Care: The Legislature and Governor want to see systemic reform, not piecemeal

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initiatives. “No more pilots” is a refrain that is increasingly heard in WA and nationally. To this end, the Chairs of the Senate and House health care committees are willing to introduce legislation as needed to help the effort succeed. Using policy levers to support reforms has precedence; in 2007, the Legislature passed [SB 5930](#), linking patient decision aids to liability reform. This first-in-the-nation program was designed to lower provider liability risk by better informing patients. Examples of potential legislation include: setting minimum standards for uniform payer submission of claims data (encounter/utilization and payment) to a data aggregator; broadening the statutory role of the Collaboratives; and reducing provider and payer liability to the extent they employ evidence-based practices. Similarly, the Model may explore the state’s authority to certify integrated care systems, such as ACOs, virtual ACOs, and RHICs.

E. The Washington Model Will Increase Statewide Coordination Among Quality

Collaboratives: The Model will strengthen the infrastructure among WA’s federal and state QI grant programs and initiatives to raise awareness of program activities, share lessons learned, collaborate around similar goals, and promote best use of limited resources. The Model will convene biannual events targeting state, regional, and local quality initiatives. Their purpose is to identify overlapping efforts and duplication to promote collaboration, share best practices, advocate for federal and state policy reform, and overall make better use of existing, limited resources.

The Model is committed to principles that align the state’s strong regional quality Collaboratives. The Model leverages the success of public/private partnerships such as those pioneered by providers (Group Health Cooperative and Virginia Mason Medical Center), and by payers (Boeing and Regence’s Intensive Outpatient Care Program,⁵ Premera’s Global Outcomes Contracts, or homegrown initiatives such as the Whatcom Alliance for Healthcare Access,

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CHOICE, or Central and Eastern Regional Health Improvement Collaboratives). Networked together, they create a strong infrastructure incorporating employers, consumers, local health agencies, tribal governments, educational systems, community service and support organizations, and faith-based organizations.

Q4: Describe value propositions and the performance and improvement objectives

By the end of the CMMI grant period, Washington State will demonstrate reduced spending from trend and better health outcomes in two costly areas of the health care system – obstetrics and managing chronic conditions, while setting the stage for reforming other episodes of care.

The Model's value proposition will work toward stabilizing expenditures and revenues by driving out waste in a predictable manner to allow systems to become more efficient. As WA learns from obstetrics and managing chronic conditions, the Collaboratives can expand and develop quality recommendations for statewide adoption of other episodes of care, (i.e., spine treatment, oncology, and orthopedics). A broad range of key stakeholders are quite invested in the proposed Washington Model because of its focus on higher value as well as the unsustainable path on which the state now finds itself. Our value proposition starts from the conclusion that the standard short-term measures to address rising costs, such as reducing prices, will not succeed. Instead, the Model must prompt systemic changes and improvements in health care. We must reform payment systems and the institutions that currently prevent patients from getting consistent quality care at the lowest cost.

The Model offers this promising approach without requiring radical changes to either the payment system or current referral patterns. In addition, as payers and providers adopt payment models based on value, the Model will introduce further reforms to emphasize shared savings while reducing reliance on traditional fee-for-service. By promoting more strategic and effective

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integration and care coordination, without requiring disruptive short-term changes in payment, the Model can provide a feasible path to meaningful improvements in health care.

The Model provides a solid value proposition to CMMI for several reasons: 1) the state already has an existing infrastructure engaged in pursuing systemic reform; 2) there are a number of successful, active, quality improvement programs already in place that can and will be leveraged; 3) stakeholders have been involved in system reform pilots for several years and strongly support the approach in this grant; and 4) the approach does not entail rushed or drastic change that would lead to failure. Instead, it uses an incremental approach that gradually transforms the service delivery system over time, thus maximizing participation and success.

As noted in other sections, the Health Care Authority is a sophisticated umbrella organization that has sponsored and overseen many of the system reform pilots in the state. The Model will rely on the Collaboratives to coordinate implementation. No lengthy startup is required, and we can rapidly begin deployment.

WA has put tremendous effort into system reforms over the past 20 years. This has resulted in trusted relationships and shared commitment among stakeholders. Starting with 1993 health care reforms and proceeding through the last decade's pilots, the state has developed a culture of cooperation where differing interests can sit down together and develop collaborative approaches. The importance of this cannot be overstated. A collaborative culture means change can happen relatively quickly. In its absence, forward movement is not possible.

Drastic systemic change sounds appealing; but in most cases it is not realistic without broad public and private support. Existing systems will not give up their business practices in favor of unknowns. They will, however, venture carefully into new territory when safeguards are in place. WA's Model does exactly this. It focuses on incentives to encourage broad, voluntary

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participation; it takes on episodes of care sequentially, and it allows flexibility in gain sharing while standardizing quality and utilization targets. This allows participants to experience success every step of the way and, more importantly, inculcates the continuous quality improvement culture needed to achieve the Triple Aim. We believe this approach will maximize success for the state and provide a wise investment for CMMI's grant funds.

Description of Study Design WA recognizes that one payment system will not fit all systems and venues. Currently, multiple contracts and payment models exist for payers and providers. We believe that multiple payers statewide can use differential payments (global payment, PMPM or enhanced fees) to meet local business needs. The Model asks that payers agree to a core standard set of quality and utilization measures for the infant/ maternal project and chronic care as a criterion for participation in the CMMI project. The Model will grant funds to offset payers' expenses associated with training, collaborative work, and evaluation. To protect proprietary needs, payers will agree to share their contracts and payments privately with the Evaluator. Performance outcomes are not payer-specific, but best practice-specific.

The Model uses the BCBS of Massachusetts Alternative Quality Contract (AQC) as a template for gain sharing -- setting a global budget and linking professional and facilities that meet defined quality and utilization goals with the payers and provider. It creates a type of blended or bundled payment that, over the long term and in the interest of the community, will bend cost trends downward. Our Model proposes to redistribute future payments based on a combination of quality and cost performance without reducing reimbursement relative to current levels for any provider. This approach to payment reform has several practical advantages: 1) It stimulates health care system transformation, while allowing a transition and time to adjust to new payment mechanisms. 2) It focuses on significant reductions in long-term cost trends

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without threatening currently-contracted payment levels. 3) It allows for quality and utilization tiers for gain sharing. To qualify for grant funding, the agreements must be structured prospectively to assure substantive change. Payers can adjust their payments per contracts (e.g. weighted average cost per episode increases) or pay an enhancement over an agreed- to annual trend. Gain sharing may be accomplished by many means (annual checks, enhanced fee-for-service payments, or PMPM payment) to allow payer flexibility. WA will evaluate both projects using the following primary and secondary aims:

Primary Aims. To estimate the impact of the gain sharing payment reform on: 1) utilization and standardized cost --avoidable emergency room visits, re-hospitalizations, elective C-sections etc.; 2) patient experience; 3) provider and staff perceptions of the work environment; and 4) clinical quality of care processes.

Secondary Aims. To estimate the impact of the gain sharing payment reform specifically on practice transformation, measured as the change in quality and utilization from baseline to the end of the performance period in an attributed population across multiple payers contracting with an intervention clinic. Evaluation will document the processes and differential rates of practice transformation within practices supported by the new multiple-payer reimbursement model (the intervention group) relative to those with similar baseline capabilities but not supported by the new multiple-payer reimbursement model (the control group). It will measure the association between the extent of medical home implementation and reductions in avoidable emergency room visits and avoidable hospitalizations and hospital readmissions. Practice and patient transformation metrics may include: 1) patient assistance and reminders (assistance of patient self-management, systems for contacting patients for preventive services, and paper-based physician reminder systems), 2) frequently used, multifunctional Electronic Health Records, 3) a

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culture of quality (physician awareness of performance on quality and patient experience, new initiatives on quality and patient experience, frequency of meetings on quality performance, and leadership invested in quality improvement) and 4) enhanced access (language interpreters, providers' spoken languages, and regular appointment hours on weekends).⁶⁷

Core Set of Quality and Utilization Measures: Both programs will use the same quality measures. The data set for these metrics will accompany the separate data files constructed for the project evaluation by an agreed party under a data use agreement similar to those used in prior projects. A composite of quality and utilization indicators will be used to provide a baseline calculation for quality indicators for the practice. The practice will have to maintain the same composite score each year of the pilot in order to receive shared savings payments. The *composite* measures the percentage of the indicators that were successfully met for any of the quality indicators. This calculation may be performed by an actuary on data submitted from health plans. The provider receives payment if the quality composite score in each observation period is within the margin of error or at or above the baseline quality composite score.

The Model will be evaluated with a cluster-randomized trial, in which the cluster is the hospital and its associated virtual delivery system of affiliated providers. The study design requires a sample size of 40 hospitals to detect clinically and economically meaningful effects of the intervention (i.e. 20 hospitals per intervention and 20 per control arm would be sufficient for 80% power and $p < .05$ of Type I error).⁸

Q5: Evidence basis for testing the model(s).

Evidence shows that provider payment reform is a work in progress. Health economists have described the research limitations on payment schemes to influence quality.^{9,10,11,12} Because of the difficulty of empirical analysis of dynamic effects of payment policies on spending

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growth, most studies are static, examining relatively short-term effects over several years. There is some evidence that providing comparative quality information to health care providers leads to improvements in the measured dimensions of quality.¹³ The recent IOM study also stressed the importance of using data to improve quality.¹⁴ Studies have also found that public reporting on quality leads to improvement in the measured dimensions.^{15,16} There is little evidence that quality reporting alone could improve health care quality and restrain costs substantially.¹⁷ Many payers include some “pay for performance” elements in their reimbursement system; and a number of studies have evaluated these reforms, with suggestive but inconsistent evidence of an effect on costs.^{18,19} Although “pay for reporting” and “pay for performance” reforms appear to have only limited effects individually, they could be more directly aligned with the episode-based and accountable-care payment reforms.

Closer to home, Boeing’s Intensive Outpatient Care Program²⁰ demonstrated improved health outcomes and reduced health spending by targeting care coordination and additional services to high risk individuals with chronic conditions. This and similar efforts created momentum in WA for more assertive management of chronic conditions.

The Bree’s obstetrics recommendations regarding infant and maternal care are based on evolving evidence of linking maternal procedures to infant outcomes,²¹ feedback reports that change provider behavior,^{22,23} and how payment and quality reforms can lead to better outcomes at lower costs.^{24,25} The Bree report has effectively drawn a road map for reform at all levels. However, to effect these changes, payment reform such as the recent Quality Incentive will require further systemic public/private payer and provider payment reforms.²⁶ This grant offers the means to educate local areas on best practices and evidence-based care and to reduce the variation noted in infant and maternal care.^{27,28}

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While the literature shows that many of the approaches we are adopting show promise, the findings are not conclusive. It makes sense, therefore, to evaluate strategies in a real setting; this Model will provide that opportunity. Given the complexity of field research, our evaluation will not render a final conclusion on effectiveness, but will contribute to the understanding of what approaches work to achieve the Triple Aim.

Q6: Theory of action.

The overall theory of action supporting the Model is a rapid cycle improvement process. It relies on 1) The Bree Collaborative to identify high-cost services with high utilization patterns and recommend evidence-based quality improvement strategies, including payment modifications; and 2) The Alliance which focuses on four elements to drive change: 1) performance measurement and public reporting, 2) performance improvement, 3) consumer engagement and 4) payment reform. The Model uses the Collaboratives and evidence-based medicine as a framework to: 1) further develop and adopt evidence-based models; 2) develop robust and transparent metrics to turn data into information for payers and consumers; 3) fully implement quality payment reform; and, 4) ultimately, apply these rapid cycle improvements to other treatments and episodes of care, such as orthopedics, oncology and cardiovascular care.

This process is consistent with the *Chronic Care Model* developed by Edward H. Wagner, M.D., Director of [The MacColl Institute for Healthcare Innovation](#), Director of The Robert Wood Johnson Foundation's [Improving Chronic Illness Care](#) program, co-founder of the [Alliance](#), and Senior Investigator at [Group Health Research Institute](#) in Seattle. The Chronic Care Model identifies systemic change needed to produce healthier patients, more satisfied providers, and cost savings. The Model summarizes the “essential elements” for improving care in health systems on different levels. These elements are the community, the health system, self-

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management support, delivery system design, decision support, and clinical information systems.

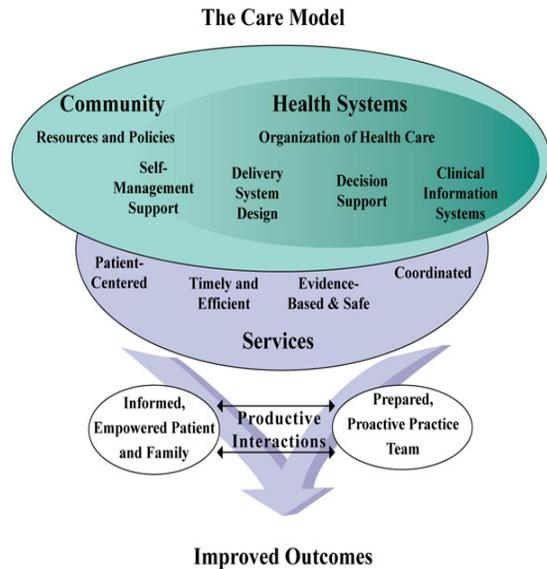
The theory can be applied to a variety of health care settings and target populations.

Q7: Identify the state’s federal initiatives and how they will incorporate.

WA has been a “pace car” state in Affordable Care Act programs. The Model leverages this participation by applying findings to inform legislation and drive programmatic policies needed to improve the state’s health care system. Since the Health Care Authority oversees most of these initiatives, it is in a unique position to assure that the Model complements those other efforts. The Health Care Authority will coordinate with other Innovation Programs and stakeholders such as the Department of Health’s Learning Collaboratives and professional organizations that share common education campaigns. The strength of the CMS Innovation Program linkages will be assessed as part of the evaluation plan. In addition, care will be taken in building the Model to ensure that savings attributed to one initiative are not double-counted.

CMS Federal Initiatives in WA State include:

1. [Health Insurance Exchange](#): Washington is one of the first states to establish an Exchange, appoint a Board, and is proceeding on schedule to start operations in 2014. The Model will work with the Exchange to explore incorporating its metrics in consumer rating tools.
2. [Medicare Shared Savings Program ACOs](#): Polyclinic Management Services Company, located in Seattle, is comprised of ACO group practices with 296 physicians.



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3. Aging and Disability Resource Centers (ADRCs): Pierce County was awarded a grant to expand the capacity to provide comprehensive education and referral services to seniors.
4. Partnership for Patients: Hospital Engagement Network Organizations: Awarded to the Washington State Hospital Association (WSHA).
5. Money Follows the Person Demonstration: Roads to Community Living. The Department of Social and Health Services (DSHS) is the lead for this project to investigate and test which services and support will successfully help people with complex, long-term care needs transition from institutional to community settings.
6. Community-based Care Transitions Program located at three sites in Washington: Pierce County's Community Connections' Aging and Disability Resources, Southeast Washington's Aging and Long-Term Care and the Whatcom Alliance for Healthcare Access.
7. Medicaid Emergency Psychiatric Demonstration Washington is one of 11 states testing improved services to Medicaid beneficiaries experiencing a psychiatric emergency.
8. Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration Seven FQHCs in Washington are participating.
9. Transforming Washington Communities: a CDC grant-funded effort to reduce chronic disease by promoting active living, healthy eating, preventive care, and tobacco cessation.
10. Section 2703 Health Homes: Washington State has submitted an application for Section 2703 health homes enhanced federal match funding. It proposes two different mechanisms: one in managed-care organizations and the other in fee-for-service programs. Both will employ chronic care management and evidence-based practices consistent with the Alliance's efforts. The two programs complement each other, while the Alliance will facilitate the development

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of metrics supporting best practices for managing chronic conditions as well as help aggregate data.

11. [Dual Eligibles Project](#): Washington State is also submitting an application to sponsor a dual eligibles project. The “Duals” project is closely integrated with the 2703 project in modifying how care is coordinated across multiple systems.

Q8: Plan for sustainability of the new payment and service delivery model(s)

Projects relying on one-time grants to fund operating expenses run the risk of faltering when funds run out. In this Model, we are dedicating funds to one-time and start-up costs, such as expanding the role of existing infrastructures (i.e., the Collaboratives) and conducting start-up activities, such as training local ACOs in efficient data submission, data analysis, and rapid cycle quality improvement. The Model is constructed as a “proof of concept” approach. If the Model proves able to bend the cost curve through utilization and global budget targets and improve quality, the Collaboratives can make a strong case for continuing these efforts using local and state funds. We are confident this will be the case because of our demonstrated success to date.

Three tenets will secure a pathway to sustainability: 1) A strong private and state payer collaboration to identify and adopt evidence-based best practices. As noted previously, WA is fortunate in having developed a culture of collaboration reflected in the successes of several reform efforts, including the Bree and Alliance collaboratives; 2) A continuous quality improvement process that examines existing practices, determines evidence-based practices, and supports broad adoption through training and payment reforms. These processes align with the missions of both Bree and Alliance and will continue long after the grant has ended; and 3) The capacity to *rapidly* collect and aggregate data to provide provider feedback and measure improvements in cost containment and quality statewide. The Model’s sustainability will be

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driven by its capacity to globally measure the impact of combinations of payment and delivery reforms. The Model's formal linkages with other CMS Innovation Programs are vital to this work.

Q9: Describe the potential to replicate the service delivery model in other states.

The Model can be replicated to accommodate differing state statutes, practice cultures, or payer and employer mixes. We proposed strategies such as evidence-based best practices and nationally recognized quality metrics; data aggregation, and feedback strategies; and linking hospitals and providers through payment and quality metrics and learning collaboratives -- each of which can be duplicated. WA's provider base mirrors much of the nation's mix of independent practitioners and integrated care systems such as Group Health Cooperative. But what may not be easily replicated is the culture of collaboration that grew over many years. WA is submitting this grant with solid stakeholder support across our state - east and west, urban and rural, private and public. As documented by the 70 letters of endorsement, WA stakeholders are committed to working together, exchanging real-time information to support evidence-based care and improve the measurement of cost and quality, empowering an ongoing continuous quality cycle.

We will support all efforts to replicate those elements of WA's Model demonstrated to be effective in improving quality and containing costs. WA experts are national leaders who will champion efforts to spread and sustain quality improvement. In doing so, we will stress the importance of building a collaborative culture where key actors focus on shared goals, rather than narrow interests.

It will be the groundwork at the local level, with community stakeholder groups such as regional health improvement collaboratives, where we will learn how to *replicate, adapt, and adopt* the model. Our greatest success in health care reform will be achieved if every community

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in WA focuses on addressing the most important quality issues in that community, with support from consumers, local health jurisdictions, and a broad range of healthcare providers. We will enlist participation by all payers, and with effective local mechanisms for monitoring implementation and resolving problems.

Q10: Describe the, geographic areas, or communities that will be the focus of model testing

All of the initiatives in this proposal are to be implemented statewide. The model will address episodes of care sequentially, and adoption will be facilitated by professional organizations across the state. The model will include small and large clinics and hospitals, urban and rural areas, and integrated and non-integrated systems by offering local ACO development, training and gain sharing. We estimate that some 50 hospitals, 500 clinics offering chronic care and 250 clinics offering obstetrical care can be accommodated over three years.

Q11: Describe the likelihood of success and the potential risk factors.

We define success as statewide adoption of evidence-based best practices to achieve the Triple Aim. The probability of our success is high, given: 1) a longstanding commitment by the Legislature to promote evidence-based care as reflected in [HB 1311](#) (Bree Collaborative), [ESSB 5394](#) (Primary Care Health Homes & Chronic Care Management), [HB 1738](#) (Consolidating Health Care Programs), and [HB 2956](#) (hospital quality incentives); 2) ongoing support and leadership from the Executive branch; 3) the maturity of broad evidence-based quality initiatives and medical home pilots in both public and private sectors; 4) existing, robust health information systems to support statewide data aggregation and feedback; and 5) strong commitment of key stakeholders as demonstrated in 70 letters of support for this grant.

Yet, the Model is not without risks. Changing delivery practices and funding models requires significant work and willingness to embrace change. Each stakeholder will need to

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create or adapt internal strategies and processes, such as forging operational and financial links between providers and facilities, introducing standardized quality metrics, and creating contractual incentives to align with the Model. Facilities will need to retool their business models in favor of those that would ultimately reduce inpatient utilization. We have mitigated these risks by engaging stakeholders in the development of the Model, providing incentives and building on the success of past collaboration.

It's worth noting *external factors* that pose a risk to the Model. Our strategies to improve health have centered on access to and affordability of care. While such steps are critical, an enormous body of evidence tells us that *external non-medical factors* like education, community conditions, and other environmental and socioeconomic factors generally have a much greater impact on health. Research from the Robert Wood Johnson Foundation confirms that the economic, social, and physical environment has a large impact on the health of our citizens. WA's Model will address this external risk by closely coordinating with non-medical efforts, including regional health efforts, and CMS projects, such as the 2703 health homes and the Dual Eligibles projects. Examples of regional efforts include the WA DOH's [Community Transformation Grant](#) and [Early Childhood Comprehensive Systems](#), rural [Lincoln County's Collaborate for Healthy Weight](#); and regional health improvement collaboratives developing in Spokane, Whatcom and other counties around the state. In developing the Model, we collaborated closely with other CMS-funded projects to assure that the Model's payment and system reforms played a complementary and supportive role. We will align strategies to address the complex intersection of social, economic, cultural, and racial factors that influence health.

Q12: Describe outcomes and the specific improvement targets

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Descriptions of current health outcomes, patients' experience, and specific improvement targets will vary depending on the specific episode of care and the defined population of focus. However, defining this information *systemically* (across payer, facility, and professional) will be expected of participants. For comparative measurement and rigorous evaluations, the definitions and processes must be collective, including a common methodology for defining episodes of care, aligning performance quality and utilization metrics, agreeing to specific improvement targets that drive clinical benchmarks, and cost goals. We will not reinvent the wheel. The Model will align with existing state quality initiatives described in Appendix 3 and national standards defined in Health People 2020, National Prevention Strategy, and the National Quality Strategy. The capacity to globally measure the evolving combinations of payment and delivery reforms that achieve maximum impact will drive the Model's sustainability.

In addition to common quality metrics, the Collaboratives will set utilization targets that link to global budgets for the episodes of care. As described under Q13, The Bree has set 37- to 39-week preterm delivery, elective inductions between 39 but up to 41 weeks, and primary C-sections as utilization measures that will reduce facility costs by increasing, when appropriate, vaginal deliveries and reducing intensive-care admissions by delivering infants at term. The Alliance will build on existing work to reduce inappropriate use of Emergency Rooms, preventable readmissions, and overall admissions resulting from chronic disease.

Q13: Describe current population health status and the target outcomes.

Target Population – People with Chronic Conditions. In WA, nearly two out of three deaths annually are from smoking and obesity-related chronic diseases, including heart disease, stroke, cancer, diabetes, and chronic lower respiratory disease (as cited in 2009 death data Vital Statistics System). It is not just older people dying from these diseases; almost one-fourth of

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these deaths are among people younger than 65. Many of these deaths are related to tobacco use, poor diet, insufficient physical activity, and alcohol consumption. They disproportionately impact communities of color, individuals with lower socioeconomic status, and other underserved sectors of the population. For example, while obesity, diabetes, and hypertension have increased for all income groups in Washington State since 1993, they all have increased more rapidly among people with lower incomes. Smoking rates have decreased for all income groups in the state since 2000, but these decreases are happening more slowly in low-income populations.

Beneficiaries of both Medicare and Medicaid (dual eligibles) are two and half times more likely than Medicare-only beneficiaries to have had five or more chronic conditions. Also highlighted is the significance of behavioral health, long-term care, and physical health needs among both elders and working-age duals, and point to the importance of efforts to better coordinate health services for this vulnerable population.

Increased health risk is evident in rural counties. Tobacco use, diabetes, and lack of screening for cholesterol, breast cancer, and colon cancer have the largest imbalance in distribution of risk by income. Since 1990, adults who are obese have more than doubled, the percent of adults with diabetes has doubled, and the number of adults with hypertension and high cholesterol has also increased. Reducing disparities by income is a priority for the Washington Model. Managing chronic disease will help achieve population-wide improvements with [Healthy People 2020](#) long-term objectives to reduce obesity, tobacco use, and heart disease and stroke death and disability.

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Measure	HP 2020 Target	Most Recent		Baseline	
		State Rate	Data Year	State Rate	Data Year
Cancer					
All cancer deaths	160.6	178.0	2007	196.0	2000
Lung cancer deaths	45.5	49.5	2007	57.6	2000
Colorectal cancer deaths	14.5	14.9	2007	18.3	2000
Prostate cancer deaths	21.2	24.4	2007	27.5	2000
HIV deaths	3.3	1.6	2007	2.1	2000
Immunization and Infectious Diseases					
Flu vaccine 65 and over	90.0	70.3	2009	72.9	2001
Pneumonia vaccine ever - age 65 plus	90.0	71.3	2009	66.9	2001
Flu vaccine -high-risk	80.0	39.7	2009	32.2	2003
Pneu. vaccine ever - high-risk, 18 -64	60.0	30.5	2009	22.0	2003
Mental Health and Mental Illness					
Suicide deaths	10.2	13.0	2007	12.3	2000

Targeted Population for Chronic Care Outcomes: Primary outcomes are 1) reductions in inpatient admissions and days, 2) inpatient re-admissions, and 3) reductions in avoidable, low-acuity Emergency Department visits. Currently, all payer outcomes are 87 hospitalizations per 1000, 340 Emergency Department users per 1000, and 17 re-hospitalizations in 30 days per 1000. While there are considerable differences between Medicaid, Medicare, and commercial populations, there is agreement in the ability to reduce the payer and local variations noted. The magnitude of these reductions will be established in each population during the planning period.

Target Population for Obstetric Care In 2011, 85,494 births occurred in the state,²⁹ and Medicaid paid for approximately half of them.³⁰ Trends report a 75 percent increase in the use of C-sections over the past decade and a drop in access to Vaginal Birth After C-sections (VBAC) services from 40 to 15 percent. In addition, the average gestational age has dropped, suggesting more early elective preterm births. The State’s elective delivery rate between 37 and 39 weeks is currently 5.4% percent (based on 4th Quarter 2011 data), down from 15.3% in 2010.³¹ An elective delivery before 39 completed weeks can increase the risk of significant complications for both

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the mother and baby, including higher Neonatal Intensive Care Unit admissions.³² Current statewide targets have been agreed to and are contained on the feedback reports:

Obstetric Measures	Current	Stated Goal
NTSV C-sections	24%	20%
VBAC's	18%	20%
37-39 week elective preterm deliveries	7%	5%

Additional work with the Collaboratives will include metric validations.

Q14: Identify other Medicare payment models and Medicaid waiver authorities,

Implementation of this grant does not rely on modification to Medicare payment models or requesting waiver authority. However, in July 2012, the state submitted a flexibility request to modify the payment methodology for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Approval of this waiver request would align FQHC and RHC payment methods with those proposed under this grant application. Currently, FQHCs and RHCs are reimbursed using an encounter-based reconciliation process. Implementing the proposed waiver would allow the state to apply a reimbursement methodology that would better support health homes and chronic care management, as opposed to volume-based encounters.

Q15: Describe how proposal could be implemented under section 1115A(d) 1) authority.

Implementation of this grant does not rely on modification to Medicare payment models or requesting waiver authority. If CMS does not approve the July 16, 2012 “Flexibility” request, this would reduce the effectiveness of the CMMI grant for FQHCs and RHCs, but would not impede the implementation of the grant.

Q16: Describe any other targeted improvements not presented above

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We intend to evaluate the model and effectiveness of the Collaboratives through a structured process of key informant interviews and feedback from stakeholders. This process will be similar to a stakeholder evaluation used in the [Health Technology Assessment program](#).

Q17a: Project processes and operational planning: Data collection and reporting

WA is a recognized leader for its capacity to facilitate collaboration among public and private payers for the purpose of data collection and reporting.³³ For example, all 84,000 state births are now publicly reported by hospitals to the Health Care Authority (via birth certificates), as well as three measures (37 to 39 weeks, NTSV C-sections and VBACs), through the Washington State Perinatal Collaborative. Similarly, while voluntary, *all* WA public agencies, the largest private payers and many large self-funded purchasers (employers and union trusts) participate in the Alliance, with payers submitting enrollment and encounter data from claims twice yearly. Since 2008, the database has been focused on a 5-county area around the Puget Sound (King, Kitsap, Pierce, Snohomish and Thurston counties). The database will expand to *statewide* data submissions beginning in fourth quarter 2012 for reporting in 2013. With the CMMI grant, the Alliance will develop the capability for scheduled data submissions from data suppliers, enabling timelier reporting of results for the agreed- upon quality metrics for primary care medical groups statewide. The Alliance will have oversight and management of data collection and reporting activities associated with the management of chronic conditions. Data extracts will include enrollment and encounter data from claims that will enable medical group/clinic level reporting on agreed- upon process measures. With the help of our policy and legislative leadership, payment data from payers will be secured and metrics will include cost of care data. The Alliance is considering becoming a CMS “qualified entity” (QE) to receive and integrate Medicare data with the robust commercial and Medicaid dataset that it already has.

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This would require additional resources not included as part of this grant application. The Foundation for Health Care Quality will continue data collection on quality measures, including the use of checklists, such as COAP, SCOAP and OB-COAP to improve patient safety.

Data analytics, performed by the participating payers, will integrate predictive modeling to identify high need patients both for payment and for care management opportunities. The Model will coordinate data aggregation with the state's 2703 Health Home and dual eligibles projects, drawing upon the state's Predictive Risk Intelligence System (PRISM). PRISM targets high-risk Medicaid beneficiaries with chronic conditions using data from medical, social service, behavioral health, and long-term care payment and assessment systems to identify clients who are in the most need of comprehensive care coordination. In addition, PRISM has begun integrating Medicare data for the dual eligible population. Private payers participating in the Model have similar risk adjustment programs (external grouping methodologies such as DRG, ETG and DxCG in analytics), which are similar to the PRISM predictive modeling. This grant's learnings will be shared across these multiple payers and assist us with standardizing reporting, enhancing risk adjustment and integrating these models into Health Information Technology solutions. Risk adjustors will help with feedback reports and incentive payments to ensure fairness for those that may be risk- selected.

Currently, 12 clinics across the state are engaged in the WA Multipayer Reimbursement Pilot, Participating providers receive a performance-based PMPM to cover practice transformations such as care coordination, expanded access, disease registries, and team-based management. Their experience suggests that delivering "real-time" data to practices for rapid improvement in quality requires access to interoperable and compatible electronic health record (EHR) data that can be exchanged in a timely fashion across different care settings. This requires

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operational mechanisms to exchange real-time clinical patient data between primary care physicians (PCPs), practice organizations, non-primary care specialists, hospitals, and emergency rooms. Essentially, the PCP should be at the center of such information exchange, but data transfers across all care settings is crucial for proper management of the episode of care, as well as the care of the person over time (beyond specific episodes of patient care).

Q17b: Provider payment systems

The Model reinforces the need for a provider payment system that is flexible to innovation but provides a path towards better coordination of care and quality improvement. WA leading commercial and Medicaid payers, including Premera, Regence, Aetna, Cigna, Community Health Plan of WA, Group Health Cooperative, Molina and United Healthcare, have pledged their commitment to participate in testing the Model. Key to this commitment was the decision to not require payers to replace existing, largely fee-for-service provider payment systems. Instead, payment reform will focus on adapting existing payment systems to better link provider and facility services through episodes of care, and provide incentive to meet quality and outcome measures. This simpler approach will: 1) enable participation by more payers; 2) reduce administrative overhead; 3) avoid significant changes to contracts; and 4) greatly speed implementation of the Model.

The modified payment approaches will include: 1) bundled rates for specific conditions or episodes of care; and 2) upfront payments for certain services to support an infrastructure capable of employing best practices. Bundled payments will combine payment for all stages of treatment, including facility and outpatient, to strengthen coordinated care and follow-up. This approach to transforming payment will work well as all WA payers (fee for service and managed care) have experience paying a global professional fee for prenatal, delivery of any type, and

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post-natal care. The Model includes bundled payments and gain sharing for meeting quality measures in episodes of care. The Alternative Quality Contract payment method is described in greater detail under [Question 4](#).

Q17c: Model enrollment or assignment processes

The Model is not designed around the enrolling or assigning of specific populations to a specific intervention. Instead, it is designed to improve how care is delivered across the system, so *any* patient who comes through the door will receive care from a provider trained and paid to deliver evidence-based medicine. Participation by providers is voluntary, but is promoted by: 1) financial stipends offered to professional organizations and provider groups to offset startup costs; 2) the prospect of uniform performance and outcome measures; 3) expanded training on best practices; and 4) financial incentives, such as shared savings and gain sharing for meeting agreed-upon performance and outcome measures.

Q17d: Contracting and administrative processes

Using the Collaboratives, we will link provider payments to a common core set of quality and utilization metrics that will link together facilities and professional and simplify administration. Efficiencies of scale will be gained statewide from promoting consistent measures that are developed, collected, and reported in a uniform manner. The current piecemeal approach to different service delivery and payment methods does not support the promotion of value-based health care and adds a significant administrative burden to provider organizations. Today, practices must juggle six to eight different quality-reporting streams to achieve payment bonuses, which exacerbates waste and encourages silos in health care. This is especially problematic for smaller, independent or rural practices with limited administrative capacity. A detailed description of the grant administration is in Q17g.

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Q17e: Continuous improvement analysis and performance optimization process

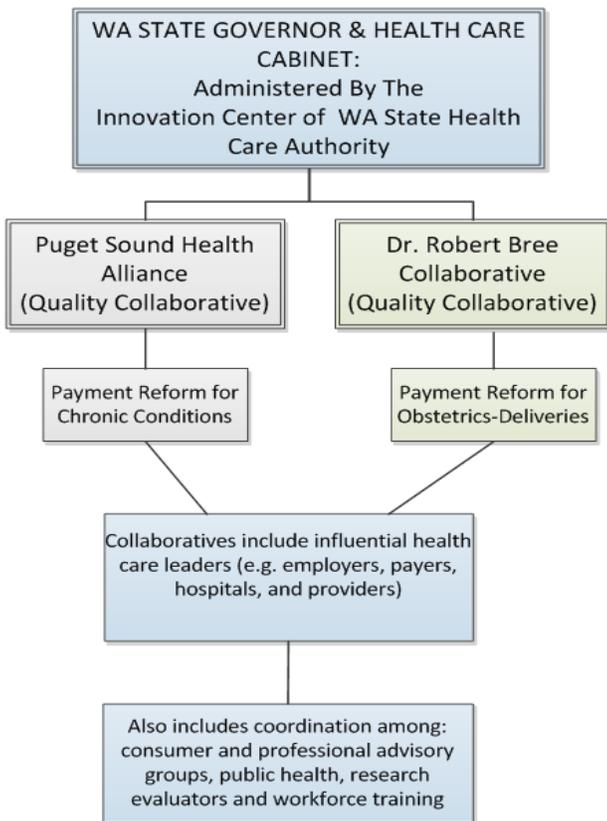
The premise of the Model is to institutionalize a statewide continuous quality improvement culture to achieve the Triple Aim. It identifies high-cost, low value episodes of care, develops evidence-based recommended best practices and payment reforms, incents adoption and provides extensive training. The Department of Health (DOH) and professional associations (WA State Medical Association and WA State Hospital Association) will partner with the Health Care Authority and the Collaboratives to provide technical training and assistance to speed adoption of evidence-based best practices. Since 1999, the DOH has offered [Learning Collaboratives](#) for health care providers. These include in-person training, webinars and other e-Tools, primary care practice coaching, community asset mapping, and other technical assistance, all of which are supported with pooled funds from federal grants and support from Medicaid health plans. Today, DOH partners with Qualis Health and the University of Washington Advancing Integrated Mental Health Solutions Center to support statewide initiatives such as the Washington Community Transformation Grant, Beacon Grant, Washington State Perinatal Collaborative, and Emergency Cardiac and Stroke System. The Department of Health can identify how to streamline CQI activities, expand existing programs, and mitigate overlapping initiatives, as well as facilitate and mobilize community partners and community health improvement efforts. The Foundation for Health Care Quality will play a critical role in promoting checklists and other quality tools to improve safety. Finally, the Health Care Authority will work with the Health Care Personnel Shortage Task Force and the state's medical schools to integrate the Model's evidence-based best practices and develop continuing medical education sessions.

Q17f: Other processes needed to complete delivery system reform

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The Model will also explore changes to help providers and payers lower their risk of liability exposure by following approved evidence-based guidelines. Practitioners often cite legal exposure as a driver of health care costs. While the magnitude of this problem is uncertain, it is clear that fears about liability often drive the delivery of unnecessary and costly tests or services. The state pioneered a program that changes provider and payer liability if they employ certified patient decision aids (PDAs).³⁴ If a patient completes a certified decision aid and understands the risks regarding unintended outcomes, the plaintiff needs to meet a higher standard of evidence.

Q17g: Project Management and governance structure



The Governor’s Health Cabinet, comprised of the Governor, lead policy staff, and health-related agency directors will provide will serve as the Executive Steering Committee overseeing implementation of the grant. Reporting to the Steering Committee is the State Innovation Model (SIM) Team, consisting of representatives from the key implementing organizations, including the Bree Collaborative, Department of Health, Department of Social and Health Services, Health Care Authority, Alliance and multiple payers. Their work will commence upon award notification. The Health

Care Authority will use internal staff to lead project management to successful implementation of grant activities. Five task forces that report to the SIM Team will be created: 1) Quality

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Improvement group (metrics and surveys); 2) Cost Improvement group; 3) Multiple Payer Data Integration group; 4) Stakeholder Engagement and Development group; and 5) Evaluation and Reporting group. At least one member of the SIM Team will attend each sub-committee meeting. Ad hoc groups will be assigned as needed. There will be consumer/advocate representation on each task force. The grant's project manager will serve on all five task forces to assure implementation proceeds in a coordinated, timely fashion.

In addition, the Legislature will provide high-level oversight to the project. The health care committee chairs will conduct periodic hearings on progress and consider possible legislation, if needed, to support the grant. The Legislature's oversight will also include its fiduciary role in appropriating grant funds to state agencies. The SIM Team will develop a monthly status report and disseminate it to stakeholders. Regular reports will detail progress, task force actions, and any barriers to progress. Common documents will reside on the dedicated SharePoint site for the grant.

Q17h: Describe the Model staffing resources and roles

Proven leadership will secure success for the WA Model. Organized as the State Innovation Model Team (SIM Team), this group's membership includes key organizational leaders: 1) Steve Hill, Chair of Bree *and* Alliance, Member of Governor's Health Cabinet, Director of Department of Retirement Systems, former Director of HCA, Board Member of Leap Frog Group and Consumers Union; 2) Jeff Thompson, MD, Chief Medical Officer for HCA, former Corporate Medical Director at Weyerhaeuser Company, Associate Editor at Milliman and Robertson, a clinical assistant professor at University of Washington (UW) in occupational medicine, and Medicine Officer in US Navy; 3) Terry Rogers, MD, CEO of Foundation Health Care Quality (FHCQ), UW clinical faculty, former Senior Medical Officer and Executive VP-

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External Affairs for Regence, 4) Mary McWilliams, Alliance's Executive Director, Past President of Regence Blue Shield of WA, and 5) Rachel Quinn, MPH, MPP, Program Director at the FHCQ, former health policy analyst Public Health (Seattle, King County); 6) Jason T. McGill, JD, Executive Policy Advisor for Health Care for the Governor's Executive Policy Office, 7) Robin Arnold-Williams, DSW, Secretary Department of Social and Health Services (DSHS), former Executive Director Utah's Department of Human Services; 8) Mary Selecky, Secretary of the Washington State Department of Health since 1999; 9) Doug Conrad PhD, lead CMMI evaluator and UW Professor, Oral Health Services and Economics and 10) MaryAnne Lindeblad, BSN, MPH, Director of the Health Care Authority (HCA), former Assistant Secretary for Aging and Disability Services Administration in the DSHS, former Director of Health Care Services Division of Medicaid.

With oversight from SIM Team (including HCA leadership: J. McGill, R. Arnold-Williams and M. Lindeblad). Jenny Hamilton, MSG will be the CMMI Project Director. Currently, Ms. Hamilton is HCA's Senior Health Policy Coordinator and she formally worked for the Office of Financial Management and was responsible for connecting OFM data and research with the development of statewide health policy; coordinating health policy and planning research activities across multiple agencies. Internal staff to hire under the direction and management of Ms. Hamilton include 5.0 FTEs: 1) Contracts Specialist, 2) Rules and Publications Specialist, 3) Data Management Specialist, 4) Quality Assurance and Reporting Specialist, and 5) Grants Manager.

B. Describe the expected transformation.

The expected transformation: Washington's health care providers will have the knowledge of evidence-based best practice and will be paid to deliver it. WA has been in the

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forefront of states emphasizing rigorous reviews of services and products to assure they are safe and effective. The Model will weave evidence-based quality assessment and adoption into the fabric of our delivery system, advancing knowledge in areas that need it the most, specifically those practice patterns with high rates of variation or high use of services that do not result in improved outcomes. The Model will raise awareness through training and create incentives for providers to deliver quality health care services. The Model will explore ways to provide additional protections to providers and payers when they are following approved evidence-based medicine. The Model prepares the provider for the “Accountable Care” future by collecting, aggregating, and providing feedback in performance measures to improve care and lower costs. The core quality and utilization metrics will be streamlined and aligned with CMS' [Physician Quality Reporting System \(PQRS\)](#) and [Meaningful Use](#) incentive programs to avoid duplicative processes. To that end, the Model has received full support from three key agencies in the state: 1) Qualis Health, which serves as the state’s Quality Improvement Organization and operates the Regional Health Extension Center; 2) the State’s Health Information Exchange, OneHealthPort; and 3) the federal Beacon Grant in Eastern Washington.

The model will transform the structure for service delivery. The most successful ACOs have integrated specialty and hospital care where expenditures are highest. Nationally, models such as the PROMETHEUS, ProvenCare (Geisinger), Group Health Cooperative (and Inter-Mountain Care are called out in literature, along with a promising model in Blue Cross Blue Shield of Massachusetts, which aligns financial and clinical goals. However, these systems are already highly integrated and do not fit those WA regions where providers operate independently from facilities (hospitals). The Model’s flexibility provides the opportunity to create virtual or functional integration of services in those regions by testing an “Alternative Quality Contract

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(AQC).” The AQC can act as a “virtual” ACOs by aligning incentives, using several key components: 1) gain sharing to provide incentives for best practices and to contain costs; 2) sharing data to reduce variation; 3) integration of systems across the continuum of care (e.g., PCP, facility and medications); and 4) additional savings for providers achieving quality improvements. This approach has particular appeal for communities that are developing regional health improvement collaboratives. Communities such as Whatcom County (Bellingham), Spokane, Thurston County (Olympia), and Clark County (Vancouver) are moving to link and coordinate services at the local level where services are delivered. The AQC provides a natural vehicle to accelerate these efforts.

Evidence of Commitment: We have provided evidence of payer and provider commitment in the letters of support attached to this application. The large provider associations, all major payers, and the state agencies have committed to the Model and the required changes.

C. Describe the roles of other payers and stakeholders participating in the model

WA has an unusually strong collaborative culture. Health care reform legislation has always prioritized stakeholder involvement, including consumers and advocates as well as payers and providers. For example, [HCR 4404](#) specifically mandated “*an advisory committee to provide advice and recommendations to the department of social and health services and the health care authority in the development of its implementation plan required by HB 1738 to coordinate the purchasing of acute care, long-term care and behavioral health services.*” Similar language is present in legislation establishing the Exchange and directing HCA to submit waivers to CMS. Successful and timely implementation can only be built on a foundation of involved communities and stakeholders. Following are the roles of stakeholders who have formally committed with letters of support for this initiative:

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State agencies will collaborate to deliver sustainable health care services that are valuable and equitable. They include: Governor’s Cabinet, Health Care Authority, Department of Social and Health Services, Department of Health, Department of Retirement Systems, Department of Labor and Industries, Department of Corrections, and State Educational Institutions.

Providers will deliver evidence-based medicine in an integrated health care system. Providers are defined as practitioners credentialed to provide health services, represented as individuals, facilities (hospitals, long term care centers, safety net providers), and their representatives in professional organizations. Provider groups include: WA State Medical Association, WA State Hospital Association, WA Academy of Family Physicians, WA Academy of Pediatrics, WA Association of Community Health Centers and Migrant Farmworkers, WA Rural Health Center Association, WA Community Mental Health Council, WA Chapter of National Alliance for Mental Illness, WA Indian Health Commission, WA Home Care Coalition, WA State Nurses Association, WA Association of Advance Psychiatric Nurses, and University of WA and affiliated hospitals.

Payers will provide incentives for providers to deliver evidence-based medicine in an integrated health care system. Payers are defined as state purchasers of health care services; health plans, carriers, and managed care organizations that are licensed to operate in WA. These entities include: Premera, Regence, Aetna, Cigna, Community Health Plan of WA, Group Health Cooperative, Molina, Multicare, Amerigroup, Renaissance Health, and United Healthcare.

Purchasers will pay for health care services that are evidence-based. Purchasers are defined as employers, Taft-Hartley Trusts, and other entities purchasing health care services for their members. These include HCA, Boeing, Costco, King County, Alaska Air, and 22 other employers represented on Bree and the Alliance.

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Public and private partnerships will identify unmet needs of community to promote the delivery of evidence-based health services. The Bree Collaborative, the Puget Alliance Sound Health, Foundation for Health Care Quality, WA Quality Improvement Organization (Qualis Health), WA Health Information Exchange (OneHealthPort), regional health improvement collaboratives (RHICs) are trusted regional partnerships that identify opportunities for improving health care quality and value, and facilitate planning and implementation of strategies for addressing those opportunities. Impacting multi-county regions RHICs are located across the state in Whatcom County, Spokane County, south Puget Sound counties, and Clark County.

Patients will be informed of the evidence-based recommendations to help make wise decisions about the most appropriate care based on their individual situation. Consumer input and active participation is critical to the Model's success and is the primary means of insuring that it will increase patient choice and positive health outcomes. The Model will create SIM *Advisory Council* as a vehicle to actively engage and seek commitment from community stakeholders in shaping the health care system in WA. Participants may include beneficiaries and their family and friends, legal advocates, WA AARP local/state representatives, educational/advocacy organizations for Medicare and other insurance, (e.g., Senior Health Insurance Benefits Assistance program), Northwest Health Law Advocated (NoHLA), the Washington Chapter of the National Alliance on Mental Illness, various faith-based organizations, and advocates for specific cultural and ethnic groups such as the Islamic Civic Engagement Project and Native American tribal representatives. WA is governed by a strict open meetings act (Chapter 42.30 RCW); consumers and advocates will be encouraged to attend implementation meetings, such as the Bree.

D. Describe linkage of Models to state's State Health Care Innovation Plan.

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The State Health Care Innovation Plan and the Model work in concert. Further, all legislative and executive parts of state government have worked closely together in developing this grant and have committed to using their individual resources and policy levers to further the aims of the grant. The State Innovation Model Team includes the Governor’s Health Cabinet, Health Care Authority, Department of Social and Health Services (including Aging and Disability Services Administration), and Department of Health who will work in unison to provide policy level support. These entities have the authority – via tools such as Certificate of Need, new regulations, new legislative proposals, etc. -- to adjust state policy levers necessary to implement the objectives of this grant. In addition, state agencies, multiple payers, providers, federal/state initiatives (such as CDC Community Transformation Program and Money Follows the Person Demonstration) and regional health improvement collaboratives have committed implementation of the grant. The state Department of Health is the lead for developing updating state plans to promote health and will help align the Model with the National Prevention Strategy, National Quality Strategy and Healthy People 2020. The Models training and education components, delivered largely through the Department of Health’s learning collaboratives covers the integration of physical and behavioral health services, as well as how to coordinate with the long-term care system. The regional health improvement collaboratives across our state provide another vehicle to bring together resources to better respond to local consumer needs, while supporting providers to integrate care across physical health, behavioral health, public health, oral health, and long-term services and supports.

The Model’s focus on integrated care delivery and measurement will drive changes in how care is delivered including the complexion of the workforce. As we implement service

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delivery changes, we expect the Collaboratives to address emerging trends in workforce shortages and gaps in training programs.

E. Multi-Stakeholder Commitment

Washington has received extraordinary support from stakeholders across the state for the this application. We received 80 letters of support from the groups described under Q17d. This level of commitment from such diverse stakeholders speaks to our state's tradition of seeking and incorporating public input. The state will continue to seek input from community groups, including Regional Health Improvement Collaboratives, and will create a *SIM Advisory Council* to provide active oversight of the grant's implementation. CMS has advised states that meaningful stakeholder engagement will result in a better product, saying, in essence, that without the involvement of consumers and other key stakeholders, integrated programs will fail.³⁵ We agree. Consumer input and active participation is critical to the Model's success and is the primary means of ensuring that it will increase patient choice and positive health outcomes.

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³ Miller HD. [Regional Health Improvement Collaboratives](#) *The Foundation for Successful Healthcare Reform, 2nd edition.* Jewish Healthcare Foundation.

⁴ Adapted from Care Management Process Figure developed by Reward Health Sciences, Inc.

⁵ Milstein B, Homer J, Briss P, Burton D, Pechacek T. [Why behavioral and environmental interventions are needed to improve health at lower cost.](#) *Health Affairs* May2011;30(5):823-32.

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Section VI. Study Design and Evaluation Washington State

Part VI: Study design and evaluation

Washington recognizes that one-payment system will not fit all systems and venues. There currently exist multiple contracts and payment models for payers and providers. To assure participation by multiple payers, the design accommodates different approaches to payment (e.g., global payment, PMPM or enhanced fees). Washington will, however, ask payers to agree to a core standard set of quality and utilization measures for the infant and maternal project and chronic care as a requirement of participating in the CMMI project. To protect proprietary needs, payers will agree to share their contracts and payments privately with the Evaluator.

Performance outcomes will not be payer specific; but, best practice or component specific.

A. Anticipated data needs: To reduce administrative burden and increase provider participation, the grant will draw upon an agreed minimal data set from the plans and the state.

Maternal and infant data. provider feedback reports, rapid cycle improvement data and evaluation will stem from three sources: 1) WA birth certificates secured through the First Steps data base from WA DOH and analyzed by HCA for feedback reporting at the hospital and provider levels, and 2) Level 3 hospital NICU outcomes stemming from chart reviews submitted to the Vermont Oxford Network (VON) and 3) the Foundation for Health Care Quality OB-Clinical Outcomes Assessment Program (OB-COAP) that will abstract maternal and infant outcomes from chart review and central a data source for rapid cycle improvements and evaluation. **Managing Chronic Conditions Data.** Data will be derived from provider feedback reports; rapid cycle improvement data and evaluation will stem from 1) data provided by health plans to the Alliance used for the [Community Checkup](#) and provider feedback, 2) Medicare data secured through a data sharing agreement with CMS (WA currently has access to parts A, B and D for dual eligibles) and 3) in kind reporting from local health plans based on claims (predictive

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modeling of clients, cost and utilization reporting) specific to clinics, hospitals and clinicians.

B. Description of data collection and performance reporting processes: WA has used the BCBS of Massachusetts Alternative Quality Contract (AQC) as a template for gain sharing by setting a global budget and linking professional and facilities that meet defined quality and utilization goals with the payers and the state. This model, which will be one of the subjects for evaluation, creates a type of blended or virtual bundled payment that -- over the long term -- should bend the trend of cost downward. Our model proposes to redistribute future payments based on a combination of quality and cost performance without reducing reimbursement relative to current levels for any provider. This approach to payment reform: (a) stimulates health care system transformation, while allowing a transition and time to adjust to new payment mechanisms; (b) focuses on significant reductions in long term cost trends, but not threatening currently-contracted payment levels, (c) allows for quality and utilization tiers for gain sharing. To qualify for grant funding, the agreements must be structured prospectively to assure substantive change occurs. Payers can adjust their payments per contracts (e.g. weighted average cost per episode increases) or pay an enhancement over an agreed to annually trend. Gain sharing may be accomplished by many means (annual checks, enhanced fee-for-service payments, or PMPM payment) to allow payer flexibility.

Study Design: The model will be evaluated with a cluster-randomized trial, in which the cluster is the hospital and its associated virtual delivery system of affiliated providers. This design will be the most effective means to minimize bias and issues of regression to the mean. The study design will evaluate 50 local ACOs (clinics and hospitals) to detect clinically and economically meaningful effects of the intervention.⁴ This design will have adequate power to detect power to detect differences of .3SD in the six core utilization measures. Core quality

**Section VI. Study Design and Evaluation
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measures will be discussed in the six-month planning period.

Table 1. Summary of Design Variables

Study Component	Baseline Rate	Estimated Standard Deviation (SD)	Min. Detectable Effect Size Sought (=3 SD)	Min. # ACOs required (at 0.3 SD Effect size)	Patients / ACO
OB/Delivery:					
Primary C-section rate*	.1480	.0419	.0126	9 intervention + 9 control	1400
VBAC rate*	.1448	.1251	.0375	9 intervention + 9 control	1400
NTSV C-section rate*	.2449	.0730	.0219	9 intervention + 9 control	1400
Pre-Term Delivery rate (<37 weeks)	.0835	.0341	.0103	9 intervention + 9 control	1400
Cost per birth and delivery episode**	\$8802	\$1651	\$495	9 intervention + 9 control	1400
CCMH:					
Hospitalization rate***	.087	.015	.0045	9 intervention + 9 control	30,000
Emergency Room visit rate***	.340	.039	.0116	9 intervention + 9 control	30,000
30-day Rehosp. Rate***	.017	=.003	=.0009	9 intervention + 9 control	30,000
Total Health Care Cost per person per year****	\$5976	\$1121	\$336	9 intervention + 9 control	30,000

C. Plans for coordinating data collection efforts with Innovation Center evaluation

contractors: WA will share with collaboratives, providers and CMMI contractors our cost, quality, and utilization in the following data sets, subject to HIPAA and confidentiality requirements. The state would like to work with CMS to improve receipt of Medicare data for non-dual eligibles.

Primary Aims: estimate the impact of the gain sharing payment reform on: 1) utilization and standardized cost, (avoidable emergency room visits, re-hospitalizations elective C-sections etc.), 2) patient experience, 3) provider and staff perceptions of the work environment, and 4) clinical quality of care processes.

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Secondary Aims: estimate the impact of the gain sharing payment reform on 1) practice transformation, measured as the change in quality and utilization from baseline to the end of the performance period in an attributed population across multiple payers contracting with an intervention clinic, 2) Document the processes and differential rates of practice transformation within practices supported by the new multi-payer reimbursement model (the intervention group) relative to those with similar baseline capabilities but not supported by the new multi-payer reimbursement model (the control group), and 3) Measure the association between the extent of chronic care, maternal and infant care implementation, that result in reductions in avoidable emergency room visits and avoidable hospitalizations (including NICU admissions), hospital readmissions and changes in OB services. The evaluation will take into account practice and patient metrics that may include patient self-management, systems for contacting patients, and physician reminder systems, electronic health records, physician awareness of performance on quality and patient experience, and enhanced access to care.^{1,2}

D. Methodology for state continuous improvement, in collaboration with Innovation

Center evaluators. WA proposes a unique set of quality and utilization reporting for continuous quality improvements. The quality and utilization measures for both programs (chronic care and maternal & infant) will have set of core and common quality and utilization measures. The data set for these metrics will accompany the separate data files constructed for the project evaluation by an agreed party under a data use agreement. Rapid cycle improvement will be implemented through regular provider feedback, DOH Learning Collaboratives and onsite technical assistance.³ DOH has had great success with learning collaborative in diabetes, asthma and primary care medical home training. WA will collaborate closely with the CMMI evaluators on ways to increase the effectiveness of our continuous improvement cycles.

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WA will use composite of quality and utilization indicators to provide a baseline calculation for quality for the practice. The practice will need to maintain the same composite score each year of the pilot in order to receive shared savings payments. The composite score measures the percentage of the indicators successfully met for the quality indicators. This calculation may be performed by an actuarial firm using data submitted to it from health plans. The provider will receive payment if the quality composite score in each observation period is within the margin of error or at or above the baseline quality composite score. These data will stem from the collaboratives to ensure appropriate attribution, risk modeling and appropriate transparency.

E. Processes for continuous learning, adoption of best practices. Essentially, the structure of the grant is a CQI model geared toward 1) identifying evidence-based best practices for specific episodes of care, 2) modifying reimbursement to support those practices, 3) providing training via learning collaboratives, and 4) providing regular feedback to providers on their performance.

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4. [Localio AR, Berlin JA, Hane TR](#) Longitudinal and repeated cross-sectional cluster-randomization designs using mixed effects regression for binary outcomes: bias and coverage of frequentist and Bayesian methods. *Stat Med* 2006 (Aug 30); 25(16): 2720-36

**Section VII. Project Plan and Timeline with Milestones
Washington State**

VII Project Plan and Timeline with Milestones

Key Action Step	Agent	Timetable	Milestones/Measures
Objective: Create Grant Administration and Structure Milestone: Develop sound infrastructure for all CMMI activity			
<ul style="list-style-type: none"> a. Appoint /Hire HCA staff for implementation: program director, contracts, data analyst, grants manager, administrative staff. b. Convene steering committee, State Innovation Model (SIM) team and subgroups. c. Negotiate contracts and review statement of work with CMMI, including milestones and deliverables d. Develop contract with stakeholders. e. Collaborate with evaluators. f. Amend State Plan, promulgate rules, and revise provider guides <u>as needed</u> to support overall work plan and each objective. g. Develop or amend contracts as needed to align with State Plan, rules and provider guides, as well as to support overall work plan and each objective. 	<ul style="list-style-type: none"> a. Governor’s Office, SIM Team = Health Care Authority (HCA), Bree Collaborative (Bree), Puget Sound Health Alliance (Alliance) b. HCA c. HCA d. HCA, Department of Health (DOH), Professional Organizations e. SIM Team, University of Washington (UW) and CMS f-g. HCA, DOH, Bree, Alliance, others. 	<ul style="list-style-type: none"> a. Month 1 b. Month 1-3 c. Month 1-3 d. Month 3 e. Month 1-6 f-g. Ongoing 	<ul style="list-style-type: none"> a. Hiring completed b. Steering committee established. c. Contracts executed d. Contract executed e. Evaluation commenced. f. Evaluation of needed changes completed. State Plan and rules amended.
Objective: Align and Incent Performance Metric Across Payers Using Contracting and Incentives Milestone: agreement on decision making/ review processes, data sharing/reporting standards, quality/utilization perf. metrics.			
<ul style="list-style-type: none"> a. Develop evidence-based best practice recommendations (EBBPR) with defined methodology supported by data analytics. b. Use EBBPR to develop performance quality and utilization (metrics) with defined targets. c. Convene with payers to complete methodology of value-based purchasing d. Collaborate with Evaluators 	<ul style="list-style-type: none"> a-c. Bree Collaborative and Puget Sound Health Alliance, Foundation for Health Care Quality (FHCQ), Payers, Providers; RDA d. SIM, FHCQ, OneHealthPort, Regional Extension Centers, 	<ul style="list-style-type: none"> a-c. OB care month 1-42 a-c. Chronic Mgt month 7-42 d. Ongoing 	<ul style="list-style-type: none"> # of episodes of care that have EBBPR # of metrics # of payers using metrics # of providers using metrics # of contracts incenting metrics # of covered lives affected by contracts

**Section VII. Project Plan and Timeline with Milestones
Washington State**

Key Action Step	Agent	Timetable	Milestones/Measures
	Alliance, FHCQ, SIM Team, UW and CMS.		
<p>Objective: Conduct Statewide Data Aggregation and Performance Metrics Reporting. Map data elements; determine which are centralized in Collaboratives and which reported by plans. Milestones: 1) report agreement, 2) execution of core elements.</p>			
a. Incorporated performance quality and utilization metrics into existing data processes such as data programming, data transfer and mapping, and report design. b. Data submission from data supplier to enable more timely reporting c. Produce and disseminate provider feedback reports. d. Collaborate to identify opportunities to complement HIE activities. e. Collaborate with evaluators	a.-c Alliance, Payers, Providers, FHCQ d. SIM, OneHealthPort, Regional Extension Centers e. Alliance, SIM Team, UW and CMS.	a. Mo 1-6 b. Mo 6 c. Mo 6 d. Mo 3 e. Ongoing	a. # of metrics incorporated into performance reports b. # of data submissions c. # of reports generated d. # of reports disseminated
<p>Objective: Build Workforce Capacity to Promote Adoption of Evidence-Based Practice and Performance Metrics. Milestones: 1) developed education/training Year 1; 2) implemented, tested and improved to increase effectiveness Year 2.</p>			

**Section VII. Project Plan and Timeline with Milestones
Washington State**

Key Action Step	Agent	Timetable	Milestones/Measures
<ul style="list-style-type: none"> a. Develop and implement hands on learning collaboratives. b. Develop and disseminate toolkit, including checklists, practical tips and adoption aids. c. Develop, disseminate and train provider on use of patient decision aids (PDAs). d. Disseminate stipends to providers/hospitals for training expenses and data collection and submission support. e. Develop CMEs to support evidence-based practice recommendations. f. Collaborate with medical/nursing schools and health workforce organizations to integrate recommendations into curriculum. g. Collaborate with Evaluators 	<ul style="list-style-type: none"> a. DOH lead, SIM Team, FHCQ and Alliance b. HCA, FHCQ and DOH c. HCA, FHCQ,DOH and Bree d. HCA, FHCQ and professional organizations e. HCA, DOH f. HCA, DOH g. SIM, UW, CMS 	<ul style="list-style-type: none"> a. Complete Month 6, implement 7- 42 b. Complete Month 6, implement 7- 42 c. Month 6 d. Month 6- 42 e. Month 12 f. Month 12 g. Ongoing 	<ul style="list-style-type: none"> a. # of learning collaboratives developed to support EBBPR metrics b. # of organizations endorsing EBBPR c. # of toolkits/education materials developed to EBBPR d. # of professional organizations that develop program or training to support adoption e. # of CME developed f. # stipends distributed g. # of school agreeing to endorse EBBPR h. # of PDAs developed i. # of organizations endorsing and using PDAs #
<p>Objective: Explore Policy Levers to Secure Adoption of Evidence-Based Care. Milestones: 1) preplanning in Year 2 and 3 prior to session for decision packages going to the Legislature and 2) reporting to the key legislative committees on policy levers.</p>			
<p>Convene to develop policy levers such as:</p> <ul style="list-style-type: none"> a. Setting minimum standards for uniform payer submission of claims data (encounter/utilization and payment) to a data aggregator; b. Broadening the statutory role of the Bree; c. Reducing provider and payer liability to the extent they employ evidence-based practices. d. Certifying integrated care systems, such as ACOs, virtual ACOs, and RHICs to support 	<p>Governor’s office, Steering Committee and SIM. Assistance from the Senate and House chairs of the health care committees.</p>	<p>Ongoing, starting in 2013</p>	<p>Scope of legislation and rule created to support delivery and adoption of evidence-based recommended practices.</p>

**Section VII. Project Plan and Timeline with Milestones
Washington State**

Key Action Step	Agent	Timetable	Milestones/Measures
professional and facility integration.			
Objective: Increase Statewide Collaboration Among Quality Collaboratives.			
Milestones are 1) preplanning in Year 1 and 2 for statewide and local meetings and 2) a web-based program for real times sharing of best practices and trends.			
<ul style="list-style-type: none"> a. Create internal infrastructure to network state and federal QI initiatives and grant programs with listservs and methods to strengthen communication and b. Create a state inventory of QI current activity and disseminate to raise awareness and knowledge of QI programs statewide c. Convene events of RHICs, federal and state QI initiatives d. Collaborate with evaluators 	<ul style="list-style-type: none"> a. HCA, RHICs, federal grants and state QI programs b. HCA c. HCA and Collaboratives d. HCA, RHICs, stakeholders, UW, CMS 	<ul style="list-style-type: none"> a. Month 1-6 b. Month 12 c. Biannual, first event Month 6 	<ul style="list-style-type: none"> a. # of QI programs participating b. # of QI programs included in the state inventory c. # of methods to disseminate inventory d. # of events e. # of participants at events
Objective: Evaluation and Reporting of Grant Activities and Findings.			
Milestones include examination of patient experience, provider and staff work/life experience in each of the three 12-month study periods. Key informant interviews will be fielded and completed in months 3-6 of each study year.			
<ul style="list-style-type: none"> a. Hire staff and participate in first 6 months planning b. Apply for human subjects approval c. Primary analysis patient experience, provider and staff work/life experience d. Secondary analysis analyses of clinical quality and utilization outcomes; Interim and Final reporting 	<ul style="list-style-type: none"> a. HCA, UW b. HCA, UW c. UW d. HCA, UW and collaboratives 	<ul style="list-style-type: none"> d. Month 1-6 e. Month 12 Biannual, first event Month 6 	<ul style="list-style-type: none"> a. # of personnel hired b. Attendance at planning meetings c. Client and provider surveys completed 1) plan data obtained, 2) data cleaned, 3) data reported in aggregate on quality and utilization