

Medical Management – Strategies and Recommendations

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Executive Summary

As the designated Lead Organization under Substitute Senate Bill 5346 (SSB5346), the Washington Healthcare Forum, with the assistance of OneHealthPort, engaged stakeholders in a structured process to propose a set of goals and work plan for the development of medical management protocols. The stakeholder consensus that emerged from that process is presented in two companion documents. The first document titled 'Medical Management - Scoping Document - February 26, 2010' discusses the challenges of medical management and defined the scope of possible opportunities for optimizing its effectiveness while minimizing its administrative burden. This, the second document, details two strategic imperatives for improving medical management and recommends specific action steps for making impact.

Medical management is a worthwhile and necessary process for minimizing unwarranted variations in patient care delivery to ensure that care is cost effective and of high quality. However, as currently implemented, medical management is not as effective or efficient as it might be. The wide variation in physician practice demonstrated by the underuse, overuse, and inappropriate use of services as well as the use of more expensive services when less expensive services are of equal benefit to patients contributes to the upward spiraling cost of care. The wide variation in health plan operational processes, especially those related to pre-authorization, contributes to the administrative cost of medical management. The reduction of both types of variation provides the greatest opportunity for controlling costs while maintaining, and potentially improving, the quality of care that is delivered.

Two strategies were identified that hold promise for controlling these variations. Those strategies are:

1. Streamline current health plan methods and provider interaction with them
2. Strengthen medical management practices of physicians

Streamlining health plan methods and provider interaction with them will reduce administrative burden on providers. Significant training and institutional knowledge is required for provider staff to keep track of which health plan requires a pre-authorization for what services, what specific procedure needs to be followed to get an authorization decision, and what information must be provided. The pre-authorization burden is especially acute for pharmaceuticals. Harmonization of operational processes across health plans and automation of these processes are essential for streamlining the pre-authorization process. To ease the administrative burden, provider organizations as well as health plans must incorporate the use of automated tools into their workflow processes. Otherwise meaningful efficiencies cannot be realized.

Strengthening medical management practices of physicians will improve patient outcomes at lower cost and with less administrative burden. Stakeholders judged this strategy likely to yield greater benefits than the prior strategy. However, this strategy is a monumental undertaking in that it is more challenging to implement, requiring fundamental change. For this strategy to take hold, a) provider reimbursement must

reward clinical outcomes rather than service volume, b) meaningful, evidence-based information must be available to providers, and c) providers must adopt automated systems and workflows so that this information can be used in real time to make appropriate care decisions for each and every patient. As these mechanisms are put in place, health plans can delegate more of the medical management to provider organizations and increase their value as an information resource.

Not enough is yet known to recommend a specific solution or set of solutions for the challenges of medical management. It will take some time to figure out what works. Coordinated action steps can and should be taken to test out new approaches for physician practice, broadly communicate learnings and encourage best practices to be put in place. In the meantime, streamlining the pre-authorization process, especially for pharmaceuticals, will ease some of the administrative burden.

Collaborative efforts to minimize unwarranted clinical variation and reduce costs are emerging across the healthcare community in the form of pilots/demonstration projects. These pilots are incubators of creative approaches and possible solutions. Additional, similar efforts should be convened. Coordination will be required to monitor and highlight well-targeted pilots so as to increase the likelihood that promising ideas are pursued in a standardized non-duplicative manner, results are verified and Fundamental Learnings are formalized and communicated.

Ideas emerging from these pilots that demonstrate results must be encouraged to take root across the provider mainstream. Nurturing these ideas will require innovation on the following fronts; a) developing an Incentive/Reimbursement framework that rewards outcome driven care, b) encouraging and enabling provider adoption of evidence-based systems and workflows, and c) implementing a communication/education infrastructure for engaging the provider community in ideas and approaches that demonstrate results.

Bottom line, in response to the SB5346 request, a set of goals and work plan for the development of medical management protocols are recommended. These recommendations promote strategies and methods for more broadly incorporating evidence-based decision criteria into provider practices to control costly, unwarranted clinical variations. In parallel, they also promote streamlining the pre-authorization process across health plans so that it less of an administrative burden. The recommendations do not promote efforts targeted at standardizing evidence-based clinical review criteria across major, commercial health plans as those efforts are unlikely to have any significant impact on the cost of care or the administrative burden of medical management.

Introduction

Senate Bill 5346 (SB5346) calls for the lead private sector organization to propose "a set of goals and work plan for the development of medical management protocols, including whether to develop evidence-based medical management practices addressing specific clinical conditions."

For the purpose of this document, and in a manner consistent with the definition set forth in SB5346, medical management protocols may include those clinical practices, operational processes/procedures and related guidelines/policies/data sets that health plans and provider organizations put in place to manage the delivery of care to a patient. Discussion within this document related to improving medical management protocols includes developing new protocols and enhancing existing ones.

This document will recommend:

1. Guiding principles for improving medical management protocols
2. High impact target opportunities for improving medical management protocols
3. A work plan for making improvements to medical management protocols and replicating them, as appropriate, across the healthcare community.

The process of arriving at these recommendations was conducted in two stages, a Scoping Stage and a Recommendation Stage. The Scoping Stage was focused on arriving at a shared understanding of medical management, its inherent challenges, and a possible direction, goals and opportunities for making an impact. Conversations included provider organizations, health plans, public payers and other stakeholders that are representative of the Washington State healthcare community. The deliverable from that stage titled 'Medical Management Scoping Document - February 26, 2010' is referenced as an appendix. *Please refer to the Scoping Document for a characterization of the medical management problem, specifics about the challenges and definitions of terms.*

The Recommendation Stage was focused on arriving at very specific approaches for moving forward. The broad set of goals and opportunities outlined in the Scoping Stage defined the starting point for conversations about where and how to make the greatest positive impact on medical management. The intent of those conversations was to identify a critical few impact opportunities for improving medical management and a work process for developing, testing out and gaining adoption for those improvements. If this work process proves successful for those critical few opportunities, it can continue to be used/refined for ongoing improvements. Representatives of the healthcare community (see Appendix) were convened as a workgroup to arrive at a consensus recommendation. This document is the deliverable from Recommendation stage.

Findings from the 'Recommendation Stage' are presented in the following sections:

- Strategies for Improving Medical Management
- Assessment of Strategies for Improving Medical Management
- Specific Recommendations for Improving Medical Management

- SB5346 - A bottom line response

Strategies for Improving Medical Management

As discussed in the Scoping Stage, medical management is both a proactive step and a retrospective response that is intended to reduce unwarranted variations in patient care delivery. Provider variations in care delivery that are the targets of medical management include underusing, overusing, or inappropriately using services, or using more expensive services when less expensive services are of equal benefit to patients (e.g. brand name pharmaceuticals rather than generics). These clinical variations unnecessarily add to the cost of care. Health plans put operational processes in place to control these clinical variations. Health plan and provider variations in operational processes add to the administrative cost of care delivery. The Scoping Stage identified goals and corresponding opportunities for improving medical management protocols to minimize these variations and their associated costs.

In the Recommendation Stage, these goals and opportunities were a) refined to make them clearer and actionable, and b) ranked based upon perceived value to all stakeholders. In the process, it was recognized that these goals naturally align with two different improvement strategies.

- Streamline current health plan methods & provider interaction with them
- Strengthen medical management practices of providers

Strategy I: Streamline current health plan methods & provider interaction with them.

Strategy I is primarily focused on improving medical management processes that are put in place by health plans and, as such, this strategy only addresses that subset of care decisions where insurance coverage applies. It is largely a "downstream" or "safety-net" strategy in that it is necessitated, primarily, because an "upstream" strategy is typically not in place. Pre-authorization is one example of a downstream process put in place by health plans to monitor that evidence-based criteria is being used since many providers do not have that capability in place.

Ranked Goals and Opportunity Targets associated with Strategy I

Strategy	Identified Improvement Goal (Ranked Order)	Opportunity Target
Streamline current health plan methods & provider interaction with them <ul style="list-style-type: none"> • Focused on health plans making coverage decisions (a subset of care decisions) 	1. Where communication between health plans and providers is required, transition from non-standard manual processes to interoperable automated ones	Simplify, standardize and automate health plan operational processes, especially pre-authorizations
	2. Eliminate health plan	Reduce pre-authorizations

Strategy	Identified Improvement Goal (Ranked Order)	Opportunity Target
<ul style="list-style-type: none"> • Downstream Strategy • Historical Approach 	medical management activities where they provide no value	where value is not demonstrated
	3. Develop a reasonable strategy for the adoption and use of common clinical review criteria across health plans	Align medical management, e.g. pre-auth, with historical provider performance
		Standardize evidence based clinical review criteria across health plans

Note: The objective of streamlining is to reduce the impact of health plan variation on provider efficiency, staff training and workflow. That objective can be achieved through a combination of a) harmonizing operational processes across health plans, i.e. taking out as much variation as possible in order to prevent provider error and b) automating operational processes, i.e. using web-based interactions, HIPAA transactions and/or other forms of electronic information exchange to reduce time spent and administrative burden on provider-staff.

As an example, a currently underway step towards streamlining the pre-authorization process is the transition from health plan specific, paper pre-authorization forms to online forms for each health plan. The process is harmonized in that providers will not need to track down different forms for different health plans or inadvertently use the wrong form. The process is automated in that forms will be posted on web sites and can be completed on line. Responding to health plan-specific pre-authorizations questions on an interactive web site is significantly easier for providers than tracking down that health plan's paper pre-auth request forms, answering the different questions, faxing it in and following up for a response. Though health plans may vary in the amount or specifics of the information they request pertaining to a pre-authorization, the burden of variation is minimized or eliminated by automation.

Strategy II. Strengthen medical management practices of providers.

Strategy II is primarily focused on improving medical management protocols that are put in place by providers and, as such, is relevant to all care decisions. It is an "upstream" strategy, in that it assumes that medical management activities will occur at the first possible workflow point as close as possible in time and location to patient interaction.

Goal and Opportunity Targets associated with Strategy II

Strategy	Identified Improvement Goal	Opportunity Target

Strategy	Identified Improvement Goal	Opportunity Target
Strengthen medical management practices of providers <ul style="list-style-type: none"> • Focused on providers making all care decisions • Upstream Strategy • Emerging Approach 	Increase provider responsibility and accountability for medical management	Adjust financial reimbursement – outcomes rather than volume
		Make meaningful & actionable data, including evidence based-practices, available to providers
		Improve processes/tools to integrate improved data
		Implement medical management practices that are, at minimum, substantially equivalent to health plans

Assessment of Strategies for Improving Medical Management

Both of the above strategies were assessed in order to anticipate the "best case improvement impact" that could be achieved if resources were committed to improvement efforts. Impact on the following improvement objectives (in priority order) was considered.

1. Achieve better patient outcomes at lower costs
2. Reduce the administrative burden of the medical management processes itself

The Best Case Impact of each strategy is projected in the table and more fully discussed following the table.

Best Case Impact on Improvement Objectives

	Achieve better patient outcomes at lower cost	Reduce administrative burden
I. Streamline current health plan methods & provider interaction with them	Low Impact	Medium Impact
II. Strengthen medical management practices of providers	High Impact	Medium-High Impact

I: Strategy I - Streamlining current health plan methods & provider interaction with them, will very likely reduce some administrative burden. However, depending upon the specific process/practice, the cost to streamline may outweigh its value.

The value of streamlining varies depending upon the specific medical management process or practices, as follows.

A. For Pre-Authorizations and Admission Notification, the **value** of additional streamlining is likely to **outweigh** its **cost**.

Significant training and/or institutional knowledge is required for provider staff to know which health plan requires a pre-authorization for what services, what is the specific procedure that needs to be followed and what information is required. The complexity and time-demands of the pre-authorization process varies by health plan. In almost all cases, some combination of phone, fax and automation is usually required.

Requesting pre-authorizations is a very high volume, standard operating procedure. Where the value of pre-authorization as a control mechanism to minimize variation cannot be demonstrated, it should be eliminated. In the much more common situation where the control mechanism does have value, it is a reasonable target for streamlining.

Streamlining the pre-authorization process would not only decrease administrative time and costs, but, in some situations, could also positively impact patient outcomes. The following illustrates how a delay in pre-auth processing can affect a patient's condition resulting in more expensive treatment.

A physician was following step up therapy recommendations for a patient's chronic asthma, advancing the patient from Flovent to Advair as the controller medication. The pharmacy could not fill the prescription change until a prior authorization was processed. By the time the pre-auth was obtained, the patient ran out of medication and developed significant asthma exacerbation requiring several acute office visits.

It is important to note that for the value of streamlining pre-authorizations and admission notification to be realized, health plans and provider organizations must both take advantage of automated tools. A one-sided effort will waste resources.

B. For 'Standardizing evidence-based clinical review criteria across health plans', the **cost** of additional streamlining is likely to **outweigh** its **value**.

The use of standard evidence-based clinical review criteria across health plans lessens provider confusion and patient anxiety about coverage decisions. It can also reduce appeals and grievances and simplify the contracting process (by

eliminating negotiations targeted at contractual concessions requested by providers for less stringent criteria.)

It is important to recognize that significant standardization of clinical review criteria across the major commercial health plans licensed in Washington State already exists. Though difficult to quantify, workgroup members estimated a standardization alignment of 95-98%. The remaining 3-5% variation falls into one of three categories:

1. Variations caused by a difference in the timing of review cycles. Health plans review and update their review criteria on a standard cycle, e.g. some plans in the first quarter, some in the second quarter, etc. Since health plans use similar sources for their evidence-based practices, they make similar decisions when updating their review criteria. Some health plans may update their criteria slightly sooner than others.
2. Variations in what is considered investigational/experimental. Health plans may have different standards for determining when a treatment is no longer investigational/experimental.
3. Variations inherent in vendor systems purchased by health plans. In many cases, health plans purchase their clinical review software from vendors. These vendors may implement the same review criteria in slightly different ways as part of their proprietary software. As such, this level of variation is totally outside of the control of the health plans. Any effort to enforce standardization across vendor systems is likely to be futile due to the proprietary nature of vendor implementation.

Workgroup members report that variation in clinical review criteria across the *major commercial health plans* IS NOT a primary cause of complexity and confusion for providers. It is the lack of standardization in clinical review criteria across the *myriad self-insured plans* that can be problematic. In many cases, self-insured plans and/or their Third Party Administrators (TPAs) a) have limited resources available for conducting evidence-based research and/or implementing rigorous policies or b) employers specify less aggressive medical management. As such, the use of evidence-based review criteria by self-insured plans/TPAs varies substantially.

Periodically, discussions about a single vendor approach for standardizing clinical review criteria surface in different forums across Washington State. This approach is NOT recommended. The technology selection and implementation processes along with the requisite ongoing statewide effort to continuously review and refine the review criteria would be expensive, time consuming and could miss the mark. Since the self-insured plans and their TPAs cannot be legally required to implement such a system or share in its cost, use of the system would be limited to the major commercial health plans, whose review criteria are already highly aligned. Any resource invested in this endeavor would, at best, eliminate

an insignificant amount of variation and remove a negligible amount of burden on the provider community.

- C. *Variation in clinical review criteria is oftentimes confused with variation in benefit design. Although variation in benefit design is significantly more problematic for providers than variation in clinical review criteria, it falls outside of the domain of medical management and will not be impacted by any streamlining of medical management protocols.*

Health plan clinical review criteria and health plan benefit design are two distinctly different things, yet are oftentimes confused. As mentioned above, major commercial health plans have limited variation in clinical review criteria. However, there may be significant variation in benefit design. To illustrate - Aetna or United or Regence may have multiple product lines - some of which cover Gastric Bypass as a benefit and some of which don't (i.e. variation in benefit design). However, when Gastric Bypass is a covered benefit, the clinical review criteria are likely to be very similar, at least across major commercial health plans.

This distinction between benefit design and clinical review criteria can be confusing to providers, patients and others. When Gastric Bypass is not pre-authorized or not paid upon claim submission, providers don't always distinguish between 'lack of benefits' or 'does not meet clinical review criteria'. Both types of denials may be lumped together. However, for this procedure it is much more common for the denial to be due to 'lack of benefit coverage' than for 'does not meet clinical review criteria'.

It is important to recognize that benefits design IS NOT a medical management issue. As such, no streamlining of medical management will have any impact on this issue.

II: Strategy II - Strengthening medical management practices of providers is very likely to improve patient outcomes at lower cost and with less administrative burden, but it is a monumental undertaking requiring fundamental change.

The current process of making clinical decisions and paying for care is characterized by volume-driven (as opposed to outcome-driven) treatment, breadth and complexity of clinical information and administrative burden. For things to change, providers themselves must be enabled and encouraged to make more consistent evidence-based decisions when treating patients.

- A. *To optimize peak clinical performance, provider reimbursement must transition from volume-driven to outcome-driven.*

For the most part, providers are paid based upon the volume of services that they deliver. Those payments are made to providers regardless of the outcome of the

treatment. More services delivered translates into increased revenue for the provider and increased cost of the encounter.

By rewarding service volume alone rather than patient outcome, the healthcare payment system penalizes peak performance. The more efficient a provider's treatment, the less they are paid. Carried to its logical extreme, the best providers could be driven out of business for delivering superb care, i.e. the highest level of patient outcome with the lowest volume of services.

To stem the rising costs while maintaining or improving patient outcome will require a fundamental change in the provider reimbursement model. Clinical results/outcomes, rather than the volume of services delivered, must be incorporated into the overall measurement of performance.

- B. To maximize medical management efficiency, health plans will increasingly be an information resource and will delegate more of the medical management to provider organizations that put in place requisite processes.*

Historically, health plans have played the role of determining which treatment services were to be covered and of assuring that clinical review criteria have been met. Approval of patient coverage can depend on: 1) providers determining if, when and what clinical information needs to be exchanged with the health plan, 2) health plan clinicians receiving and reviewing patient information prior to the patient's treatment, and 3) coordinating interactive discussions between clinical decision makers in the health plan and provider organization. This staff intensive and time-consuming back-and-forth process between provider and health plan contributes to friction among the health plan, provider and patient.

A more efficient process would have provider organizations on point for making sure their care decisions meet health plan requirements for coverage, once eligibility and benefits have been determined. That process would have the following characteristics.

1. Providers would have access to more, better and increasingly standard information sets. Health plans would be an information resource about provider-specific variation and about providers who are controlling variation. This information would be available to provider organizations for use when making care decisions. Information from health plans and other sources would be meaningful and actionable to providers. This information is likely to consist of, but may not be limited to, outcome expectation data, cost data, and evidence-based practice data. Ideally, the information to be used by providers to manage care decisions would be acceptable across health plans.
2. Providers would have technology and workflow in their organizations that enable them to consider treatment options using evidence-based information. Provider organizations would have the requisite technologies and workflows to effectively use that information in "real time" to consider treatment options for each patient in a manner comparable to the health plan process. Those

decisions would include "hard stop decisions", i.e. a given treatment would absolutely not be provided when specific criteria is not met.

3. Internal review and health plan review/audit of provider's medical management. Health plan accrediting bodies (e.g., URAC or NCQA) require health plans to ensure that provider groups who do medical management for a health plan's members have effective programs and processes in place that meet the accrediting body's requirements. To meet these requirements, provider organizations would have a structure in place whereby a clinician(s), other than the one treating the patient, would review selected care decisions and provide comments and recommendations for corrective measures, where appropriate, to the patient's care giver(s). Health plans would periodically work with the provider organizations to review the findings and provide comments on the effectiveness of the medical management processes.

Note: Though an essential medical management practice, an internal review structure such as this would be challenging and costly for most provider organizations to put in place. Smaller practices may not have the resources to take on these delegated activities and/or to put in place a self-auditing system without changes in reimbursement and infrastructure changes in their offices.

III. Blending Strategies I & II into a coordinated, well focused, and step-wise approach is the recommended course of action.

Strengthening medical management practices of providers is the best hope for significant and sustainable improvement in patient outcomes while controlling the cost-of-care and minimizing administrative burden. However, adoption and implementation of a provider-enabled strategy is a long-term prospect that is most reasonable to pursue as part of a coordinated step-wise process. To provide some near-term easing of the current medical management administrative burden while the longer-term process is underway, some narrowly focused streamlining of existing health plan methods and provider interaction with them should proceed in parallel.

Specific Recommendations for Improving Medical Management

A new course for medical management practices and processes needs to be charted. The key elements of this course are:

- Principles for guiding **what** should be done
- A compass for determining **where** to focus
- A work plan for **how** to get things done

I. Efforts to improve medical management should be guided by a core set of principles. (What should be done!)

Recommended principles are:

A. Medical management practices of providers should be strengthened so that care delivery is increasingly outcome-focused, evidence-based and administratively streamlined.

Outcome-focused delivery of evidence-based care with minimum administrative burden will require charting a new course for medical management practices and processes. The starting point is mutual reduction in variation. Providers must be prepared to reduce variation in clinical care. Health plans must be prepared to reduce variation in operational processes. For the new course to take firm hold, outcomes-based reimbursement must factor significantly more than volume-based reimbursement and adoption of automation must be widespread.

Beginning now and over the long term, providers need to be more actively involved in and accountable for medical management. Their adoption of evidence-based systems will likely be required in order to enable and sustain improved medical management practices as an integral part of the patient interaction. As provider organizations take on increasing responsibility for medical management, health plans can expand their role to become more of a clinical information resource than a control point in care delivery.

In the near term, health plan operational processes must be increasingly harmonized (i.e. variation reduced to a minimum), automated and aligned with "best practice" recommendations. Providers must take advantage of automated capabilities made available by the health plans.

B. Meaningful data should be available to providers in a timely manner.

In support of outcome-focused care, clearly defined & appropriate outcome metrics must be in place and meaningful data must be available to providers in "real time", or as close as possible. The definition of "appropriate" and "meaningful", along with the data that meet those criteria, will evolve over time as experience is gained.

C. Community-wide learning leading to subsequent implementation of best practices should be supported and facilitated.

Not enough is yet known about this new course for any specific medical management solutions to be mandated. Pragmatic and step-wise development of continuously improving care practices is essential.

The evolution of medical management protocols is most likely to take shape in the form of clinical pilots/demonstration projects that are targeted at achieving a specific improvement outcome(s), such as an increase in generic utilization rate for pharmaceuticals. Essentially, these pilots are learning laboratories that will produce 'Fundamental Learnings' for the rest of the healthcare community about what works and what doesn't (e.g. metrics, data sets, workflows, technologies, etc.). To illustrate, a Fundamental Learning from a Medical Home pilot might be 'The effectiveness of the medical home increased as ancillary staff initiate contact with patients with chronic conditions'. Some level of coordination and management will likely be necessary to ensure that these Fundamental Learnings are broadly communicated across the healthcare community.

Ideally, these Learnings will contribute to the implementation of 'best practices' within health plan and provider organizations, i.e. clinical, operational and information exchange practices that will achieve the targeted improvement outcome.

The communication of Fundamental Learnings is necessary but may not be sufficient for widespread implementation of best practices. Appropriately coordinated efforts outlined in 'A', 'B' and 'C' above is likely to be required.

II. Reducing variation, and its associated costs, without compromising care should be the compass for selecting and pursuing opportunities for improved medical management. (Where to focus!)

As discussed above, initial steps towards improving medical management should be targeted at reducing variation without compromising care. Reducing provider variation in care delivery should lead to equal or better patient outcomes at lower costs. Reducing health plan variation in operational processes should lessen the administrative burden of the current medical management process.

The challenge is not a lack of opportunities where impact can be made, rather it is "where best to start" and "how to proceed".

A. Reduce provider variation in care delivery to better manage the cost of care

Pilots/demonstration projects should be targeted at clinical conditions/practices where there is the greatest opportunity to reduce costs associated with unwarranted variation. A pilot could be patient-visit-focused (practices related to

the conditions of a specific patient) or population-focused (practices related to care of a population of patients, e.g. NCQA diabetes score).

When evaluating a target opportunity for a pilot, the following impact considerations should be quantified.

1. What is the current level of overall expenditure (spend)? The higher the current level of expenditure for a given clinical condition or practice, the greater the total opportunity for savings.
2. What is the level of expected impact by making a change (impact)? In other words, how much reduction in clinical variation, and associated expense, is reasonable to expect without compromising care. The greater the reduction, the greater the opportunity for savings.
3. What is the level of difficulty in making a change (difficulty)? The lower the level of difficulty in making a change - or the costs associated to enable the change - the increased likelihood for success in achieving the savings.

The ideal target opportunities are those where the 'spend' and 'impact' are high and the 'difficulty' is low. However, it is likely that these ideal opportunities will be few and far between, as fundamental and sweeping change is likely to require significant time and effort. Quantifying and finding the right balance of these three considerations, so that expectations are appropriately set, is an important part of the process of selecting and designing a specific pilot.

A list of impact opportunities for reducing costly variation is included as an Appendix. That list was compiled from each workgroup member's top three impact opportunities, and is not intended as an exhaustive list or as an exclusive list. From that list, the following impact opportunities were identified by the workgroup as highest priority.

Target Impact Opportunity - Highest Priority
1. Reduce "unnecessary" ER visits (especially for patients with chronic diseases)
2. Reduce preventable admissions and readmissions based on analysis of data, e.g. CHF, COPD, Pneumonia, etc.
3. Increase the utilization rate for generic pharmaceuticals.
4. Reduce utilization of unnecessary advanced imaging (headache, low back pain)
5. Reduce utilization of highly expensive specialty drugs when a reasonable alternative is available.

Each of these opportunities is broad enough to be the target of multiple, non-duplicative pilots/demonstration projects. In other words, it is reasonable for more than one pilot to be convened for any of these targeted opportunities without being duplicative, depending upon the scope of the pilots. Taking Opportunity #2 as an example, one pilot may be underway to reduce preventable admissions for

congestive heart failure patients while another pilot is targeted at reducing unnecessary admissions for pneumonia patients.

The Appendix also contains a list of recent/ongoing collaborative pilots/demonstration projects targeted at these opportunities. (Note: this list only includes collaborative pilots/projects that were identified by the workgroup. This list is not intended as an exhaustive list or as an exclusive list. A number of additional pilots targeting high impact opportunities are getting underway.)

B. Reduce health plan variation in operational processes to better manage the administrative cost

The administrative cost associated with medical management is the day-to-day operational burden of provider - health plan interactions to exchange information so that clinical coverage decisions can be made and communicated. This administrative cost includes scheduling delays and sub-optimal allocation of resources pending coverage decisions. In addition, the cost of care is also impacted when a delay in coverage decision adversely affects a patient's condition leading to the need for even more expensive care.

This administrative burden is shouldered by provider organizations and health plans. Providers are burdened by trying to manage the variation in medical management processes across health plans. Health plans are burdened when providers do not take advantage of automated process/on-line tools that are available to streamline medical management processes.

There are two aspects to this burden and both must be addressed in order to make significant and sustainable impact on administrative cost. The top priority opportunity to address each aspect of the burden is identified in the table and outlined below:

Operational Target Areas - Top Priority
Increase visibility into and streamline (i.e. harmonize/automate) pre-authorization process and requirements, especially for pharmaceuticals
Enhance use of information technology, including web-based tools & EHRs (e.g. utilization review or E-Prescribing systems either provided on-line by the health plan or embedded in the provider EHR) which both serve to educate, assure best practice care, and meet evidence based guidelines.

- To decrease the provider's administrative burden and improve patient outcomes, streamlining the pre-authorization process is essential. Providers need better visibility into when a pre-authorization is required and what information must be provided. Operational differences across health plans need to be harmonized and intuitive, automated processes put in place. The most pressing need relates to the pre-authorization of pharmaceuticals, whether those pharmaceuticals are covered under a patient's pharmacy benefit

or medical benefit. (Note: two different processes are required depending upon which benefit applies.)

Variations in handling prescriptions can result in adverse patient outcomes as well as administrative burden. Those variations may be related to operational processes by health plans and/or ordering practices by physicians (the latter falls within the context of efforts outlined in 'A' above to reduce variation in physician practices). Effective and timely filing of prescriptions with notifications to the prescribers are components of the variations that should be addressed in the context of these efforts.

- To decrease the health plan's administrative burden, automated processes that are available to providers, either from the health plan or from their practice management/electronic health record (EHR) vendor must be adopted. Use of automation will minimize the impact of variations in health plan pre-authorization requirements. In addition to reducing administrative burden, some of these automated tools, e.g. EHRs, e-prescribing, etc. will impact the cost of care by educating providers about best clinical practices and evidence based guidelines.

III. The work plan calls for an ongoing, innovative effort to coordinate pilots, communicate lessons learned and encourage the implementation of best practices for improving medical management. (How to get things done!)

Ongoing coordination of well targeted pilot efforts will insure that multiple, diverse 'learning laboratories' can proceed in parallel, allowing interested groups of provider organizations and health plans to pursue impact opportunities that are meaningful to them in a way that is cost effective for them. Coordination will insure that impact opportunities are pursued in a standard and non-duplicative manner, results are verified and Fundamental Learnings are formalized and communicated. Innovation will create the appropriate environment for fostering improvements in medical management.

The following are milestones to be reached. A two-year timeframe appears to be reasonable for developing the requisite deliverables and putting a support structure in place.

A. Develop and validate an overarching Coordination Methodology that will set the direction for continuously improving medical management.

A methodology should be developed and put in place for convening and coordinating numerous, diverse provider-health plan pilot efforts. This methodology will track learnings from parallel efforts so that they can be leveraged by other organizations with results being validated or refined. Over

time, these learnings will be formalized as 'Fundamental Learnings' to be broadly communicated across the Washington State healthcare community.

Capabilities addressed in the Coordination Methodology should include, but not necessarily be limited to:

1. Convening pilots/demonstration projects

Pilots/demonstration projects targeted at high impact opportunities should be convened. In some cases, the catalyst for convening a pilot may be one or more individual health plan(s) / provider organization(s). In some cases, a private sector entity such as the Washington State Healthcare Forum (Forum), Puget Sound Healthcare Alliance (Alliance), Washington State Hospital Association (WSHA) or Washington State Medical Association (WSMA) may convene a pilot/project. In other cases, a public sector entity such as the Health Care Authority (HCA) may be the catalyst.

However these are convened, pilots/demonstration projects that are pursuing impact opportunities with the intent to improve medical management processes may voluntarily register their efforts so that progress and learnings can be monitored and leveraged by other interested organizations.

Pilots/demonstration projects are likely to identify some or all of the following, as appropriate:

- Definition and scope of the impact opportunity that they are pursuing, the objectives that they would like to achieve, and methods they intend to use for self-evaluation
- New operational methods/processes/technologies that they are putting in place to achieve those objectives
- Metrics for identifying the clinical and process outcomes that they would like to achieve.
- Data sets/information that will be made available
- Incentive and/or new reimbursement strategies that may have been used

2. Monitoring & Communicating status, learnings and results

On a voluntary basis, pilots/demonstration pilots will periodically be reviewed/interviewed to gain insight into status, learning and results. Findings to be made available are likely to include the effectiveness of, and/or refinements to, the:

- Operational methods/processes/technologies
- Metrics
- Data sets/information
- Incentive and/or new reimbursement strategies
- Results of self-evaluation

3. Translating the results into Fundamental Learnings

As pilots/demonstration project mature and stabilize, their findings and results will be translated and formalized into Fundamental Learnings, which are the building blocks that organizations can use to design and implement best practices.

B. Convene a Care Innovation Process that will enable and sustain medical management improvements.

The Coordination Methodology will provide the framework for keeping track of and assessing separate pilot/projects that spring up in the community. For these independent efforts to become mainstream, community-wide innovation will be required. A Care Innovation Process will provide the structure for defining the innovations and fostering the development and adoption of requisite capabilities to enable and sustain those innovations.

Areas of focus of the Care Innovation Process should include, but not necessarily be limited to:

1. An Incentives & Reimbursement framework for transitioning to outcome-driven care

Innovative incentive and reimbursement strategies will likely be required to transition from volume-driven care to outcome-driven care. These strategies may range from operational incentives such as 'Provider Gold Cards' that can be implemented on an organization-by-organization basis, to innovative reimbursement strategies that can be implemented as a fundamental change in healthcare financing across the community. As these strategies evolve, so too will the medical management roles and responsibilities of providers and health plans. The Care Innovation Process needs to consider and define new strategies, roles and responsibilities.

Note: A collaborative effort of health plans, provider organizations and other stakeholders will likely be required to consider and devise strategies that can and will be adopted across the Washington State Healthcare Community.

2. Workflow and technology changes at the point-of-care

"Future state" workflows and technologies may be required in order for provider organizations to implement best practices. The Care Innovation Process needs to identify what these workflows and technologies are likely to be and, potentially, identify credible sources and/or solutions for their implementation in provider offices. Provider organizations may need access to people who are trained in facilitating adoption of work culture changes, i.e. the ability to work with practitioners and their staff, identify the barriers they

encounter to providing optimal care, and working with them to redesign processes and implement best practices

Note: Though the results of this process may be valuable to provider organizations, the evaluation of technologies and workflows will be extremely time-consuming given the ongoing, rapid evolution of information technologies and the wide variation in operational workflows of the different sizes and specialties of provider organizations. To the extent that this work makes sense, it may best be undertaken by entities that have a) a keen sense of the needs and capabilities of specific providers' organizations and b) the resources to dedicate to those endeavors for their members/constituents.

3. Infrastructure for engaging the provider mainstream

In order to implement best practices within their organizations, providers need to become aware of and knowledgeable about the target improvement opportunities & incentives, Fundamental Learnings and enabling workflows and technologies. As a minimum, communication and education will be required. To the extent that the provider mainstream is heterogeneous in their needs and capabilities, the methods, techniques and incentives for outreach and education may vary. The Care Innovation Process needs to identify how best to engage the spectrum of provider organizations and develop the materials and methods to do so.

Note: A single, focused outreach effort to the provider mainstream is likely to gain more attention, yield better results and be more cost effective than multiple, disparate efforts by a variety of organizations. As such this effort may be best carried out as a collaborative effort of health plans, provider organizations and other stakeholders. Messaging, materials and communications strategies could be developed collaboratively. The communication strategies can speak to how best to engage the spectrum of providers and who will have the responsibility for engaging them, e.g. WSMA, WSHA and/or other types of organizations.

C. Expand the innovative efforts of the Pre-Authorization (PA) Workgroup to include operational harmonization, in addition to automation, as Best Practice approaches for streamlining pre-authorization, to include authorizing pharmaceuticals.

A Pre-Authorization (PA) Workgroup is currently in place and has developed a number of Best Practice Recommendations (BPRs) in response to the requirements of SB5346. With an expanded focus, the workgroup would develop additional BPRs outlining how health plans might periodically review their pre-auth requirements to ensure that value is demonstrated, increase visibility into their pre-auth requirements & the value of them and harmonize/automate their

processes, with a specific focus on pharmaceuticals. The best practices that are recommended for health plans would assume that providers use automated tools.

Brief synopses of the BPRs that have been developed by the PA workgroup are provided as an Appendix.

SB5346 - A bottom line response

SB5346 makes a two-part request related to medical management. The previous sections of this document fully respond to that request. A bottom line recap of the response for each part of that request is presented below.

1. *Propose a set of goals and work plan for the development of medical management protocols*

The goals and work plan are outlined in the section of this document titled 'Specific Recommendations for Improving Medical Management'

2. *Propose whether to develop evidence-based medical management practices addressing specific clinical conditions*

Evidence-based medical management practices addressing specific clinical condition are in place today, to varying degree, within health plans and provider organizations.

- The incorporation of *evidence-based decision criteria* into provider practices is likely to have significant impact on patient outcomes and cost control. However, competitive drive and patient benefit may not be compelling enough for the mainstream of providers to overcome the integration hurdles. We need to learn more in order to figure out what can and should be done. The recommendations above lay out a reasonable path. A change in financial incentives may be necessary.
- Further development/improvement of *evidence-based clinical review criteria* across major, commercial health plans will have minimal impact on the administrative burden of medical management and is unlikely to reduce unnecessary clinical variation in provider practice.

APPENDICES

- A. Healthcare Organizations Participating in the Recommendation Stage
- B. Impact Opportunities for Reducing Costly Variation
- C. Best Practice Recommendations from Pre-Authorization Workgroup
- D. Recent/Ongoing Collaborative Pilots/Demonstration Project Targeted at High Impact Opportunities
- E. 'Medical Management Scoping Document - February 26, 2010'

Appendix A

Healthcare Organizations Participating in the Recommendation Stage

Providers

Harborview Medical Center
HealthPoint (formerly Community Health Centers of King County)
Lakeshore Clinic
Northwest Physicians Network
Providence (WSHA Representative)
Puget Sound Family Physicians
Sound Family Medicine
The Everett Clinic
Virginia Mason Medical Center
Washington State Medical Association
Wenatchee Valley Clinic
Yakima Urology Associates

Health Plans

Aetna
Cigna
First Choice
Group Health
Kaiser Permanente
KPS Health Plans
Molina
Premera
Regence
United Healthcare

Other Payors

Department of Social and Health Services
Department of Labor and Industries

Other Stakeholders

Office of the Insurance Commissioner
Washington Health Forum
Washington State Health Technology Assessment Program

Appendix B

Impact Opportunities for Reducing Costly Variation

Target Area	Specific Impact Opportunity
Reduce utilization of Hospital, ER and SNF resources	1. Reduce preventable admissions and readmissions based upon analysis of data, e.g. for CHF, COPD, Pneumonia, etc.
	2. Reduce "unnecessary" ER visits - especially for patients with chronic diseases (method - improve ambulatory access, engage patient in their own self care)
	3. Reduce ambulatory sensitive admits using Agency for Healthcare Research and Quality (AHRQ) criteria
	4. Reduce days in NICU (metric - NICU days per 1000 live birth)
	5. Zero nosocomial injuries
	6. Increase community alternatives to SNF (e.g, reduce readmission rates to SNF) to maintain patients/client in home and community settings.
Reduce utilization of unnecessary, ineffective and/or highly expensive procedures and drugs	1. Reduce utilization of unnecessary advanced imaging (headache, low back pain)
	2. Reduce utilization of highly expensive specialty drugs when a reasonable alternative is available.
	3. Reduce utilization of unnecessary/ineffective drugs, e.g. pain medications
Increase utilization rate for generic pharmaceutical and patient compliance with medication instructions	1. Increase the utilization rate for generic pharmaceuticals.
	2. Improve patient medication compliance following office visit and hospital discharge (method - engage patients in their own self care)
Increase rates for timeliness of preventive services and for chronic disease controls	1. Increase diabetic and lipid control
	2. Increase completion rates for vaccines and immunizations
Increase compliance with evidence-based protocols and criteria	1. Increase compliance with evidence-based protocols for cancer management
	2. Increase compliance with evidence-based criteria for cardiology diagnosis and procedural service
Increase transparency into the most effective and efficient physicians and hospitals	1. Increase transparency into the most effective and efficient physicians and hospitals, so that this information is available to the referral process. (Assure access to quality care and foster provider relationships)
Reduce injured worker disability	1. Reduce injured worker disability

Appendix C

Best Practice Recommendations from Pre-Authorization Workgroup: **Brief Synopses**

1) Extenuating Circumstance around Pre-Authorization and Admin. Notifications

Goal: Prevent claims from denying for lack of pre-authorization or admission notification when extenuating patient situations make it impossible for providers to a) obtain a pre-auth before services are delivered or b) to notify the health plan within 24 hours of a patient's admission.

Summary: For the extenuating situation identified below, providers should contact the health plan as soon as the information is known to them and prior to submitting a claim. Claims will not be automatically denied for lack of 24-hour admission notification or for lack of pre-auth as long as the services meet the health plan's criteria for clinical necessity.

- Providers do not have insurance information on file for the patient and are unable to get correct insurance information from the patient for a specified set of reasons.
- Patient requires immediate or very near term medical services and the clinical timeframe for performing these services make it impossible for the provider to complete pre-auth work prior to service delivery.

2) Standard Notification Timeframes for Pre-Authorization Requests

Goal: Pre-authorization requests will be processed, and providers will be notified, within common and consistent timeframes so as to optimize the efficiency of the scheduling process and the timeliness of care delivery to patient.

Summary: Pre-Authorization decisions will be made and providers will be notified within timeframes that meet or exceed standards established by the National Committee for Quality Assurance (NCQA), based upon the acuity of the patient's need for care or treatment. (Note: NCQA timeframes are consistent with those of URAC and ERISA.) In some cases, a more accelerated Best Practice timeframe is suggested. In all cases, these timeframes are the longest that the decision-making and notification process should take. In many situations, the process will be timelier

3) Browser Capabilities for Pre-Authorization and Notification of Admission

Goal: Simplify the process of determining if a pre-authorization is required, requesting a pre-authorization, getting an authorization number and giving notification of admission.

Summary: Health plans that require pre-authorization or admission notification will make interactive, browser-based capabilities available to providers to do the following;

- 1) Determine if a pre-authorization and/or admission notification is required for a healthcare service
- 2) Submit preauthorization requests
- 3) Communicate authorization confirmation
- 4) Give notification of admission

Health plans that offer benefit advisory, and similar optional prospective review services, will make this information available to providers via interactive, browser-based capabilities.

Appendix D

Recent/Ongoing Collaborative Pilots/Demonstration Projects Targeted at High Impact Opportunities

Target Impact Opportunity - Highest Priority	Pilots/Projects
1. Reduce "unnecessary" ER visits (especially for patients with chronic diseases)	Boeing Intensive Outpatient Care Program (IOCP)
	Patient Centered Medical Home (PCMH) - 3 distinct initiatives <ul style="list-style-type: none"> • DOH, WA Academy of Family Practice, WSMA & clinics • Group Health • Swedish-Premera • HCA, DSHS, PSHA, health plans and clinic
	Group Health ED & Inpatient Improvement Program
2. Reduce preventable admissions and readmissions based on analysis of data, e.g. CHF, COPD, Pneumonia, etc.	Boeing Intensive Outpatient Care Program (IOCP)
	Patient Centered Medical Home (PCMH) - 3 distinct initiatives <ul style="list-style-type: none"> • DOH, WA Academy of Family Practice, WSMA & clinics • Group Health • Swedish/Premera • HCA, DSHS, PSHA, health plans and clinics
	State Action on Avoidable Rehospitalizations (STAAR)
	Group Health ED & Inpatient Improvement Program
3. Increase the generic utilization rate for pharmaceuticals.	Generic use and Dispense as Written (DAW) Reports as tailored communications to provider organizations
4. Reduce utilization of unnecessary advanced imaging (headache, low back pain)	<ul style="list-style-type: none"> • Evidence-based Guidelines/Checklists • WA state sponsored collaborative Advanced Imaging Management (in progress)
5. Reduce utilization of highly expensive specialty drugs when a reasonable alternative is available.	Monitoring and Reporting

1. Reduce "unnecessary" ER visits

A. Intensive Outpatient Care Program (IOCP)ⁱ

Intended to reduce utilization and costs for Boeing employees and pre-Medicare retirees and their adult spouses in non-HMO medical plans that were predicted to fall in the highest quintile of medical spending.

Patients were invited to enroll in the IOCP if they received primary care through one of the three physician groups and had a severe chronic illness likely to benefit from intensified primary care. Patients who accepted were connected to a care team that included a dedicated RN care manager and an IOCP-participating MD, either their prior PCP (in one physician group) or a new IOCP-dedicated PCP (in two physician groups). Each IOCP-enrolled patient received a comprehensive intake interview, physical exam, and diagnostic testing. A care plan was developed in partnership with the patient. The plan was executed through intensive in-person, telephonic and email contacts – including frequent proactive outreach by an RN, education in self-management of chronic conditions, rapid access to and care coordination by the IOCP team, daily team planning huddles to plan patient interactions, and direct involvement of specialists in primary care contacts, including behavioral health when feasible.

Evaluation of results occurred in the Spring of 2009, after 276 patients had both participated in the program for at least 12 months and could be matched based on health spending risk factors to a non-participating Boeing-insured patient in the predicted high-cost quintile. Reported 20% reduction in per capita medical costs, 15-18% improvement in patient mental and physical functioning and timeliness of care assessments, 57% reduction in patient-reported workdays missed in last 6 months compared to baseline.

B. Patient Centered Medical Home (PCMH) Projects

PCMH projects attempt to improve the quality and reduce the cost of medical care by strengthening patient / primary care physician relationships, improving the coordination of care, preventive care, and timely interventions to reduce the impact of chronic disease.

PCMH design:ⁱⁱ

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient’s healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Example Local Participants:

Washington Patient Centered Medical Home Collaborative:ⁱⁱⁱ

Washington State Department of Health, Washington Academy of Family Practice and the Washington State Medical Association (WSMA), primary care clinics.

Patient Centered Medical Home Multipayer Reimbursement Model:^{iv}

Area health plans, Health Care Authority, Department of Social and Health Services, Puget Sound Health Alliance, multispecialty group practices and primary care clinics.

Group Health Medical Home:^{v vi}

Group Health Cooperative

All projects are ongoing. In May 2010, Group Health reported the results of their medical home pilot in *Health Affairs*:^{vii} “The results show improvements in patients’ experiences, quality, and clinician burnout through two years. Compared to other Group Health clinics, patients in the medical home experienced 29 percent fewer emergency visits and 6 percent fewer hospitalizations. We estimate total savings of \$10.3 per patient per month twenty-one months into the pilot.”

C. Group Health Emergency Department and Hospital Inpatient Improvement Program (see 3D below)

2. Reduce preventable hospital readmissions

A. Intensive Outpatient Care Program (IOCP) - see above

B. Patient Centered Medical Home Projects – see above

C. State Action on Avoidable Rehospitalizations (STAAR)^{viii}

Intended to reduce avoidable readmissions, this project is funded by the Commonwealth Fund and coordinated by the Institute for Healthcare Improvement (IHI), this project deploys continuous quality improvement methods at the individual hospital level to understand and reduce avoidable readmissions.

Participants include: IHI, Washington State Hospital Association, MultiCare Allenmore Hospital, Evergreen Healthcare, Good Samaritan Hospital, Harborview Medical Center, Jefferson Healthcare, Kadlec Regional Medical Center, PeaceHealth St. John Medical Center, PeaceHealth St. Joseph Hospital, Providence Sacred Heart Medical Center & Children's Hospital, Skagit Valley Hospital, Sunnyside Community Hospital, MultiCare Tacoma General, Virginia Mason Medical Center, Whitman Hospital and Medical Center

Results are not available at this time.

D. Group Health Cooperative

Group Health launched its Emergency Department and Hospital Inpatient Improvement Program^{ix} in June 2009. The program seeks to improve patients' experiences with care transitions and reduce preventable hospital admissions, readmissions, and emergency room visits.

Strategies included:

- Hold four five-day working sessions with front-line staff and physicians to develop ideas, approaches, and new standard work processes for improving each component of a hospital stay.
- Develop standard processes, based on best practices, to improve: hospital admissions and discharges; emergency room procedures; admissions to skilled nursing facilities (SNFs); and arrangements for palliative care.
- Triage all new patients at the time of hospital admission to determine the level of care coordination they will need.
- Inform patients in the hospital about the care they will need following discharge.
- Contact patients within 48 hours of hospital discharge to answer questions and address continuing care needs.
- Ensure that patients at risk of readmission visit their physicians within 14 days of discharge.
- Conduct in-person interviews with patients readmitted to hospitals to evaluate reasons for readmission.

In June 2010, preliminary results were released showing improvement in hospital readmission rates. The number of readmissions per 1,000 Medicare Advantage members was 8.5 percent lower in the nine months following the program's implementation than it was in the previous nine months.

3. Increase the generic utilization rate for pharmaceuticals

The Washington State Department of Social and Health Services (DSHS) has been active in improving prescribing practices. According to a 26 state survey of Medicaid pharmacy utilization, Washington was 23rd with a 63% generic fill rate. Some states have achieved a 79% rate; health plans and some clinics achieve >80% generic rate. Each 1% increase in generic use carries a \$4 million savings potential.

Several strategies were deployed, including an education campaign whereby low generic use and/or high “Dispense as Written (DAW)” providers were sent reports detailing their generic utilization by drug class and their use of DAW. DAW means that a generic drug cannot be substituted. In addition, periodic communications were sent to providers to provide suggestions on how to improve performance as well as updates on the results of the program.

In February 2010 the following was reported to providers:^x

We provided 824 prescribers with their baseline measures in six therapeutic classes if they were below 80% in generic prescribing or above 25% in DAW, or one or more standard deviations from the mean on each measure:

- *112 prescribers are now above 80% generic prescribing and below 25% DAW in ALL six therapeutic classes*
- *Of the other 712 prescribers, for at least one therapeutic class:*
 - *29% improved both generic and DAW*
 - *54% improved generic only*
 - *45% improved DAW and*
 - *18% had no change*
- *In the best practice group (top quartile), 47% improved both generic and DAW, 85% improved generic only, 49% improved DAW and 13% had no change. 160 providers have moved up to best practice group!*

Other payors and several provider groups have launched similar efforts to improve quality and cost-effective prescribing practices. Some participate in pay-for-performance initiatives that incentivize improvements in prescribing.

4. Reduce utilization of unnecessary advanced imaging

Multiple entities are involved in attempts to incorporate evidence-based guidelines or checklists in decision-making regarding the use of advanced imaging such as CT and MRI scans. In 2009, House Bill 2105^{xi} was passed which directed state payors to incorporate such an approach.

An example of such an effort is that undertaken by Washington State Labor and Industries (L&I). In June 2010, L&I implemented utilization review (UR) guidelines for MRI scans of the spine and upper and lower extremities and CT and MRI scans for headaches.^{xiii} Providers access a secure website to request authorization. The website presents them with guidelines-based checklists specific to the type of imaging

being requested. After completion of the checklists, the automated software provides a prior authorization number if online criteria are met, or a “pending” decision if not met. UR personnel review Pending decisions and coverage may subsequently be approved or denied.

L&I has established a pilot program for provider groups that allow for an expedited authorization process if the provider group meets criteria that indicate that the provider group has an effective and substantially equivalent process of evidence-based review within the provider group.

Several health plans have similar web-based prior authorization systems for automated review of compliance with evidence-based guidelines for advanced imaging. Some also provide expedited review processes for providers with historical high compliance with guidelines.

The State of Washington has called together a collaborative of health plans and providers and charged them with developing an approach to reducing unnecessary advanced imaging. The initial group has established key principles for intervening. A subset of the initial group has funded a project manager and is attempting to put in place one common approach to optimal utilization of advanced imaging. There will be a “gold card” option for provider organizations that manage this process internally with good results.

5. Reduce utilization of highly expensive specialty drugs

Premera Blue Cross^{xiii} and Kaiser Permanente^{xiv} have reported on efforts to manage specialty drug utilization. Those efforts include measuring and reporting provider prescribing patterns, increasing compliance with clinical guidelines and criteria for appropriate use, and improving prior authorization practices. Other payors and some provider groups have deployed similar efforts.

ⁱ <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/?source=promo>

ⁱⁱ <http://www.pcpcc.net/node/14>

ⁱⁱⁱ <http://www.doh.wa.gov/cfh/MH-Coll/default.htm>

^{iv} http://www.hca.wa.gov/medical_homes.html

^v <http://www.grouphealthresearch.org/newsroom/newsrel/2010/100504.html>

^{vi} pages 12-14: <http://www.ahipresearch.org/pdfs/innovations2010.pdf>

^{vii} <http://content.healthaffairs.org/cgi/content/abstract/29/5/835>

^{viii} <http://www.ihl.org/IHI/Programs/StrategicInitiatives/STateActionOnAvoidableRehospitalizations/STAAR.htm?TabId=1>

^{ix} pages 10-11: <http://www.ahipresearch.org/pdfs/innovations2010.pdf>

^x DSHS Pharmacy News, Issue 2, February 2010

^{xi} http://www.hta.hca.wa.gov/documents/imaging_workgroup_bill2105.pdf

^{xii} Click on Advanced Imaging UR tab:

<http://lni.wa.gov/ClaimsIns/Providers/Treatment/UtilReview/default.asp#4>

^{xiii} <http://content.healthaffairs.org/cgi/content/abstract/25/5/1347>

xiv <http://content.healthaffairs.org/cgi/content/abstract/25/5/1340>