

STATE PARTNERSHIPS TO IMPROVE
QUALITY: MODELS AND PRACTICES FROM
LEADING STATES

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STATE PARTNERSHIPS TO IMPROVE QUALITY: MODELS AND PRACTICES FROM LEADING STATES

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EXECUTIVE SUMMARY

It is widely recognized that many patients in the United States do not receive appropriate, evidence-based health care. Many states recognize a significant opportunity – and need – to improve health care quality, not only to improve individual care experiences but also to contain costs, expand access, improve population health, and improve health system performance. Given the complexity and fragmentation of the current health care system, with multiple payers, providers, and systems of care, states recognize they must collaborate across agencies and branches of government, as well as with the private sector, to improve system performance.

This report focuses on 10 leading state quality improvement partnerships – interrelated broad-based partnerships, mostly with public and private sector representation, which have long-term, statewide, systemic quality improvement strategic intent, and transparent agendas. They are:

- The Center for Improving Value in Health Care (CIVHC), Colorado;
- The Kansas Health Policy Authority (KHPA);
- Partnership of the Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition;
- The Massachusetts Health Care Quality and Cost Council (HCQCC);
- The Minnesota Health Care Value Exchange (HCVE);
- Partnership of the Oregon Quality Corp, the Oregon Patient Safety Commission, the Oregon Health Policy Commission, and the Oregon Health Fund Board;
- The Pennsylvania Governor’s Office of Health Care Reform (GOHCR);
- The Rhode Island Quality Institute (RIQI);
- The Vermont Blueprint for Health (Blueprint); and
- The Washington Quality Forum (now an informal partnership of the Washington State Health Care Authority and the Puget Sound Health Alliance).

These partnerships vary along a continuum of formality and scope. They build on varying histories of collaboration in each state and arise from different needs and aspirations. Nevertheless, they share a long-term commitment to multi-pronged, strategic, broad-based, and systemic improvements. Many of the partnerships are linked to broader state health reform initiatives, and most explicitly or implicitly focus on improving quality of care and improving value in the health system.

These 10 state quality improvement partnerships provide a way for their states to streamline quality improvement efforts so that they are efficient and not duplicative. The partnerships attempt to be strategic, comprehensive, and long term in their planning, but also to identify “quick wins” – proven initiatives that provide concrete results in a relatively short time. Partnerships take advantage of successful models in other states, which provide lessons learned along with ideas for quick wins. In their efforts to improve quality and system performance, partnerships tend to employ five broad interrelated strategies:

- Data collection, aggregation, and standardization for performance measurement;
- Public reporting and transparency of quality and/or cost data to drive accountability and improvement;

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- Consumer engagement to drive change and encourage care self-management;
 - Provider engagement through evidence-based practice improvement tools and guidelines; and
 - Payment reform and alignment of financial incentives to encourage value-based purchasing.

Representatives of the profiled state quality improvement partnerships reported that public-private collaboration across all sectors of health care is by nature worthwhile and necessary because no single stakeholder group can transform the health system alone. These partnerships aim to facilitate the change process by fostering communication and collaboration among participants who might otherwise avoid, oppose, or compete with each other. Partnership members cite a variety of both process and project accomplishments. Process accomplishments include increasing communication and improving relationships among stakeholders or partners, sustaining stakeholder engagement, developing infrastructure, and building consensus. Project accomplishments include launching initiatives, collecting quality and cost data, publishing reports and data, facilitating the implementation of policies or passage of laws, gaining recognition by national or federal programs, and documenting care improvements.

The importance of three factors – leadership, transparency, and sustainability – emerged throughout interviews and discussions with leaders of the 10 state quality improvement partnerships:

Leadership – Partnership representatives noted that high-level leaders must be involved in governance both at the onset and as conduits between the partnership and stakeholders. Involving people with clout conveys the importance of the partnership’s efforts.

Transparency – The state partnerships continuously balance the need and desire for public input with the need to keep work moving forward. Members unanimously agree that their partnerships increase transparency and foster collaboration, communication, and information sharing among key stakeholders.

Sustainability – Partnership representatives consistently described the importance of obtaining and ensuring adequate funding and support. Quality improvement partnerships are long-term commitments that take time to develop and see results and therefore need long-term funding and stakeholder engagement.

Each of these areas is vital to the success of a partnership, and leaders identified challenges and lessons learned associated with each one, as described in the report.

It is a daunting task to create a broad-based state partnership that promotes multi-pronged, strategic, systemic improvements in the health care system, yet efforts by state quality improvement partnerships can move quality improvement agendas forward. The key factors, policies, and practices that influence the quality improvement partnerships in these 10 states offer insights for achieving systemic improvement in health care quality and performance.

BACKGROUND/INTRODUCTION

All too often patients fail to receive appropriate, evidence-based health care in the United States. The Institute of Medicine's *Crossing the Quality Chasm* report called for a restructuring of the American health system to ensure the provision of high quality care—care that is safe, effective, patient-centered, timely, efficient, and equitable—to patients.¹ Despite being first in spending, the U.S. health system falls behind other countries in providing patients with this type of care.²

Additionally, health care quality, spending, and utilization vary across the country. Scorecards from the Commonwealth Fund have determined that quality, efficiency, and equity vary widely by geographic region, state, and within states by subpopulation and care setting.³ Studies have found that patients in regions that spend more on health care receive significantly more care, but not better quality care or outcomes than patients who live in regions that spend less on health care.⁴ Similarly, hospitals that spend more on care do not perform better on quality indicators than hospitals that spend less.⁵ Systemic changes are especially needed to address persistent racial and ethnic disparities in care quality.⁶

Leading states outperform lagging states on many performance indicators, but all states—even leaders—have areas in which they can improve. For example, about one-half of patients in the bottom-ranking states receive care that meets established guidelines and recommendations, compared to about three-quarters of patients in the top-ranking states.⁷ Many states have recognized a significant opportunity—and need—to improve health care quality, not only to improve individual care experiences but also to contain costs, expand access, improve population health, and improve health system performance. In short, state health policies are a major factor in the variability of health care quality and overall system performance, and states can learn from each other about policies and strategies to improve quality of care.

Given the complexity and fragmentation of the current health care system—with its multiple payers, providers, and systems of care—states recognize the need to collaborate across agencies and branches of government, as well as with the private sector, to improve system performance. Changing the delivery system requires collaboration to ensure consistency in measurement, information, and incentives. Many states are leading or participating in partnerships that promote quality improvement, and in many states there are multiple partnerships undertaking various quality initiatives. In a previous NASHP survey, 20 states reported that they partner across state agencies and/or the private sector to provide information to consumers and providers, to measure and improve the quality of care, and to develop policy recommendations.⁸ Multiple state agencies have a role in health care delivery or oversight, including the departments of health, insurance, Medicaid, aging, mental health, and corrections. Public-private collaboration can enable states to pool more data and to create uniform measures, benchmarks, provider incentives, and payment methodologies.⁹ Such collaboration is critical to align the various quality improvement initiatives underway within states and to leverage and strategically target resources.

Despite states' interest in unified strategic partnerships and agendas to improve health care quality and system performance, there are few opportunities for state partnerships to interact and share experiences, and there is a lack of detailed information about them. States need this information to fully consider the factors that set apart the leading states and to identify promising policies and approaches for replication. Through this Commonwealth Fund-supported project, NASHP examined public-private and state-level interagency agendas for improving quality of health care, so it could identify success factors for the following 10 partnerships (see Appendix C for partnership summaries):

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- The Center for Improving Value in Health Care (CIVHC), Colorado;
 - The Kansas Health Policy Authority (KHPA);
 - Partnership of the Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition;
 - The Massachusetts Health Care Quality and Cost Council (HCQCC);
 - The Minnesota Health Care Value Exchange (HCVE);
 - Partnership of the Oregon Quality Corp, the Oregon Patient Safety Commission, the Oregon Health Policy Commission, and the Oregon Health Fund Board;
 - The Pennsylvania Governor’s Office of Health Care Reform (GOHCR);
 - The Rhode Island Quality Institute (RIQI);
 - The Vermont Blueprint for Health (Blueprint); and
 - The Washington Quality Forum (now an informal partnership of the Washington State Health Care Authority and the Puget Sound Health Alliance).

Understanding the key factors, policies, and practices that influence these quality improvement partnerships may offer insights for achieving higher quality and improved system performance.

The report is organized to reflect the balance that these 10 state quality improvement partnerships face between competing needs of focusing internally on partnership development and externally on strategic initiatives. It focuses more heavily on internal processes rather than external strategies, since more information is readily available elsewhere on quality improvement strategies.¹⁰ In addition to information about partnership internal processes and external initiatives, the report discusses the value, accomplishments, and impact of partnerships as perceived by members and summarizes key themes and lessons.

METHODOLOGY

NASHP, which began this project by examining the State Scorecard on Health System Performance, noted that there appeared to be significant overlap between states that had some sort of quality partnership and those that rank in the top quartile of state performance in quality.¹¹ While recognizing the inability to make a causal attribution, NASHP sought to identify key attributes of state partnerships and how they might contribute to higher quality.

In the summer of 2008, NASHP convened an advisory group of state and private sector representatives with expertise in quality improvement agendas and initiatives (see Appendix A). The advisory group reviewed a list of key attributes to identify both state quality improvement partnerships to be included and a protocol for interviews with partnership representatives (see Appendix D). With the advisory group’s feedback, NASHP proceeded, using the following key attributes to identify state quality improvement partnerships for inclusion in this project:

- **The partnership has an ongoing, statewide, and systemic quality improvement strategic intent.** Its work concentrates on improving quality of care, as evidenced by its vision, mission statement, strategic plan, or objective. Additionally:
 - Efforts are ongoing, rather than ad-hoc or time-limited, and represent a long-term commitment to quality improvement.

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- Efforts are not limited to specific populations, care settings, diseases, conditions, or geographic areas within the state.
 - Efforts are intended to result in systemic improvements to quality of care and build system-wide capacity for quality improvement and measurement.
 - **The partnership is an umbrella entity.** It serves as an umbrella of interrelated partnerships, as evidenced by its influence upon and involvement with the coordination of multiple state agency or public/private quality efforts. This could include coordinated strategies such as developing quality standards, measuring quality of care, public reporting of quality indicators, implementing best practices, providing quality incentives, and convening interested parties or stakeholders in other ways.
 - **The partnership has public representation in its governance structure.** The structure, be it a board, advisory council, steering committee, or other formation that leads the partnership, includes state cabinet-level representation or representation from multiple state agencies.
 - **The partnership's work includes participation by and collaboration with representatives from multiple state agencies and stakeholder groups.** The partnership actively involves representatives from multiple state agencies, sectors and stakeholder groups (e.g. providers, consumers, purchasers, advocates, and regulators) by including them in governance and the planning and implementation of projects (as demonstrated by workgroup or committee membership). They are also included in governance as recipients of information and resources that the partnership has, acquires, or creates and then disseminates (such as reports, newsletters, websites, ad campaigns, publications such as score cards, and additional outreach materials).
 - **The partnership has a public and transparent agenda.** Information about the partnership's activity and intent are readily available and apparent to the public. Publishing annual reports, strategic plans, or similar publications is one way in which a partnership might demonstrate a public agenda.

NASHP conducted an environmental scan to identify quality improvement partnerships that had the above attributes. Sources included recommendations from the project advisory group, prior NASHP research, and searches for news stories about quality improvement partnerships. The environmental scan identified 10 partnerships that appeared to have the aforementioned attributes. NASHP then conducted phone interviews with public and private sector partners in each partnership (see Appendix D for the interview protocol).

NASHP invited one public and one private sector partner from each of the 10 included partnerships to an in-person meeting in February 2009 (see Appendix B). Lessons from that meeting were combined with interviews and background material to inform this report.

STATE QUALITY IMPROVEMENT PARTNERSHIP INTERNAL PROCESSES

A broad-based partnership at the state level can create a critical mass of purchasers, providers, regulators, health plans, and consumers committed to changing the status quo. The group can be strategic and intentional about approaches to improve quality and value in the health care system. Above and beyond undertaking particular initiatives (e.g. medical homes), the profiled partnerships focus primarily on how to plan strategically and to engage critical partners to develop and implement roadmaps for the state. They continuously build infrastructure and work to sustain partner and leader engagement as they develop initiatives to improve quality and system performance. Convening partners provides an opportunity to leverage leadership, data, and other resources in order to develop these roadmaps. As many of these state partnerships develop strategic agendas, they identify a series of interrelated strategies they can employ to reach their goals, prioritize these steps, and consider how to engage critical stakeholders to implement plans. The section discusses the profiled partnerships' purposes and missions, origins and structures, partner roles, funding, and processes for setting priorities.

PURPOSE AND MISSION

The partnerships included in this report focus on convening a broad array of stakeholders to develop statewide goals and coordinated health policy agendas for improving health care quality and system efficiency. Their missions and descriptions share many common components, such as:

- Coordinating the collection of health care quality data;
- Adopting a set of measures to evaluate and compare health care cost, quality, and provider performance;
- Publicizing health care quality and cost information;
- Promoting technology to standardize data and improve care;
- Identifying and developing cost control and quality improvement strategies, including effective purchasing;
- Helping providers consistently deliver care based on best-known practices; and
- Promoting chronic care management and health promotion strategies.

The mission statement of every formal partnership profiled in this report either explicitly or implicitly focuses on improving quality of care and containing costs, using terms such as health care “value,” “effective purchasing,” “containing growth,” and “efficient care.” In some cases this focus illustrates partnerships' emergence through broader health reform initiatives. For instance:

- The mission of the Rhode Island Quality Institute is to dramatically improve the quality, safety, and value of health care in Rhode Island.
- In its mission statement, the Center for Improving Value in Health Care mentions that it seeks to develop long-term strategies, recognizing the tremendous challenge inherent in transforming the health care delivery system.
- The Massachusetts Health Care Quality and Cost Council's mission is unique in that it specifically targets the reduction of racial and ethnic disparities in care.

- Maine does not have a mission for its informal partnership, but the three contributing organizations perceive their three organizational missions as complementary, with each one supporting the others.

Table 1 briefly describes each of the 10 partnerships included in this report, as well as their missions.

TABLE 1: STATE QUALITY IMPROVEMENT PARTNERSHIP DESCRIPTIONS AND MISSIONS

State	Partnership Name	Description and Mission
CO	Center for Improving Value in Health Care (CIVHC)	CIVHC is an interdisciplinary entity that aims to bring consumers, businesses, health care providers, insurance companies, and state agencies together to develop long-term strategies for ensuring better value for the money spent on health care in Colorado each year and to improve the service delivery system to improve quality and drive down costs.
KS	Kansas Health Policy Authority (KHPA)	KHPA is a state agency that works to develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion-oriented public health strategies
ME	Maine Quality Forum (MQF), Quality Counts (QC), and Maine Health Management Coalition (MHMC) (There is no formal partnership name.)	The Maine quality improvement partnership is one among three equal parties (a “three-legged stool”) that supports a range of quality initiatives in the state. The partnership does not have its own mission, though the three organizations have complementary missions each related to improving health care quality and/or value in the state.
MA	Massachusetts Health Care Quality & Cost Council (HCQCC)	The HCQCC is a broad umbrella organization whose mission is to develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs, while improving the quality of care, including reductions in racial and ethnic health disparities.
MN	Minnesota Health Care Value Exchange (HCVE)	The HCVE is a partnership of five organizations: Buyers Health Care Action Group, Institute for Clinical Systems Improvement, Minnesota Community Measurement, Smart Buy Alliance, and Stratis Health. Its purpose is to support HIT standards, quality standards, price standards, and incentives to promote high-quality, efficient care.
OR	N/A	Oregon has an informal public-private partnership to coordinate, communicate, and implement a range of quality initiatives in the state. Partners include the Oregon Health Care Quality Corporation, the Oregon Patient Safety Commission, the Oregon Health Policy Commission, and the Oregon Health Fund Board. The partnership has no formal name, but legislation to formalize the partnership as the “Oregon Quality Care Institute” is under consideration as of May 2009.
PA	Governor’s Office of Health Care Reform (GOHCR)	GOHCR administers the Prescription for Pennsylvania (Rx for PA), which the governor’s health care reform initiative. It is a set of integrated strategies to eliminate system inefficiencies, better manage chronic conditions, eliminate hospital acquired infections, enact insurance reforms, offer access to affordable insurance for the uninsured, and ensure that everyone has access to quality health care.

State	Partnership Name	Description and Mission
RI	Rhode Island Quality Institute (RIQI)	RIQI is an independent 501 (c)3 organization that brings together CEO-level leaders from health systems, health insurers, physicians, state employers, consumer advocates, the state's QIO (Quality Partners of Rhode Island), and academia. RIQI's mission is to dramatically improve the quality, safety, and value of health care in Rhode Island.
VT	Vermont Blueprint for Health (Blueprint)	The Blueprint guides a comprehensive and statewide process of transformation designed to improve health maintenance for a general population, as well as health care and prevention for the most prevalent chronic conditions, thereby reducing the negative health and economic impact of poorly controlled disease
WA	N/A	The Washington Quality Forum was created within the Washington State Health Care Authority (HCA) to help spread the regional multi-stakeholder Puget Sound Health Alliance (Alliance)'s activities. The Forum was to do this by identifying and disseminating information regarding variations in clinical practice patterns across the state and by identifying ways to both realize statewide data collection and support the alliance's database of quality and performance information. A hiring freeze and budget shortfall led to the Forum's termination. The HCA and the Alliance continue to partner on health reform initiatives.

PARTNERSHIP ORIGINS AND STRUCTURES

The 10 state quality improvement partnerships vary along a continuum of formality and scope. They build on varying histories of collaboration in each state, and arise from different needs and aspirations. Nevertheless, they share a long-term commitment to multi-pronged, strategic, broad-based, systemic improvements.

Origins

Some quality improvement partnerships developed organically, while others were more prescriptive. In many cases, state quality improvement partnerships were established through executive order or legislation (e.g. Colorado's Center for Improving Value in Health Care, the Kansas Health Policy Authority, the Massachusetts HCQCC, Pennsylvania Governor's Office of Health Care Reform, and the Vermont Blueprint for Health). In other states, high level leadership was critical to convening the partnerships (e.g. Maine partnership, the Minnesota Health Care Value Exchange, and the Rhode Island Quality Institute).

In some states partners collaborated on specific projects before the partnership existed, whereas in other states the partnership helped foster new relationships. Although individual members of state quality improvement partnerships may have long histories of collaboration on specific projects, the partnerships themselves mostly are in their infancy. The Rhode Island Quality Institute, with the greatest longevity, was established in 2002; other partnerships are within their first year of operation (e.g. Colorado's CIVHC, the Minnesota HCVE). Oregon and Washington laid the foundation for development of formal state quality improvement partnerships, but those states are awaiting legislative authorization or funding and are meanwhile proceeding as informal partnerships. Those established through executive order or legislation were authorized within the last four years.

Almost half of the partnerships were created as part of a broader health reform initiative (e.g. Colorado's CIVHC, the Massachusetts HCQCC, the GOHCR in Pennsylvania, and Vermont's Blueprint). One of Maine's three critical partners, the Maine Quality Forum, was also established through health reform legislation.

TABLE 2: STATE QUALITY IMPROVEMENT PARTNERSHIP ORIGINS

State	Partnership Name	Origin
CO	Center for Improving Value in Health Care (CIVHC)	Executive order (2008)
KS	Kansas Health Policy Authority (KHPA)	Executive order and legislation (2005)
ME	Maine Quality Forum (MQF), Quality Counts (QC), and Maine Health Management Coalition (MHMC) (There is no formal partnership name.)	Informal conversations led to first formal partnering for AF4Q grant (2006)
MA	Massachusetts Health Care Quality & Cost Council (HCQCC)	Legislation (2006)
MN	Minnesota Health Care Value Exchange (HCVE)	Accord (2008)
OR	N/A	N/A
PA	Governor's Office of Health Care Reform (GOHCR)	Executive order (2003)
RI	Rhode Island Quality Institute (RIQI)	Informal conversations (2002)
VT	Vermont Blueprint for Health (Blueprint)	Legislation (2003)
WA	N/A	Legislation (2007)

Governance Structure

The 10 state partnerships operate within a continuum of formality, ranging from entities with formal mission statements, governance structures, and work plans with obligations to report their progress to state policymakers, to informal partnerships comprised of cross-pollinated boards and intentional project collaboration. Most of the formal state partnerships have a board or council that sets the direction and priorities for the group and guides its work (e.g. Colorado's CIVHC, the Kansas Health Policy Authority, the Massachusetts HCQCC, Minnesota HCVE, the Rhode Island Quality Institute, and Vermont's Blueprint). Board members represent a diversity of engaged stakeholders, including state officials (e.g. legislators, purchasers, regulators, and data organizations) and private sector partners (e.g. employers, private purchasers, professional associations, quality improvement experts, consumer advocacy groups, and private foundations). Many state quality improvement partnership board members represent multi-stakeholder organizations in their states, and many state partnerships have workgroups that involve additional stakeholders in the planning and implementation of specific strategies.

Regardless of stakeholders, partnership members noted the importance of getting direction from champions and key leaders. Several partnership representatives noted that their boards are comprised of individuals who are recognized as "thought leaders," as opposed to representing particular organizational perspectives.

In those states without a formal mission statement, governance structure, and work plan, there is an informal alliance of existing organizations and partners:

- The Maine partnership’s lead partners are multi-stakeholder organizations – the Maine Health Management Coalition, Maine Quality Forum, and Quality Counts. They formally came together through a joint application to the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative to improve health across the state. They continue to partner on related projects, such as the launch of a multi-payer medical home pilot in 2009.. In conjunction with the local regional health information organization, they formed the Maine Chartered Value Exchange Alliance in 2008.
- If Oregon is able to develop its partnership as envisioned, state agencies, including the Office for Oregon Health Policy & Research, the Oregon Health Fund Board, Oregon Patient Safety Commission, and Oregon Public Employees’ Benefits Board will be key partners.
- The Washington State Health Care Authority is attempting to build on the work of the Puget Sound Health Alliance, which collaborates with 16 data-supplying partners – including large employers, county governments, and regional health plans – as well as medical groups and other stakeholders, in order to bring data collection efforts statewide.

TABLE 3: STATE QUALITY IMPROVEMENT PARTNERSHIP GOVERNANCE STRUCTURES

State	Partnership Name	Governance Structure
CO	Center for Improving Value in Health Care (CIVHC)	Board
KS	Kansas Health Policy Authority (KHPA)	Board
ME	Maine Quality Forum (MQF), Quality Counts (QC), and Maine Health Management Coalition (MHMC) (There is no formal partnership name.)	No separate governance structure; leadership teams for initiatives
MA	Massachusetts Health Care Quality & Cost Council (HCQCC)	Council Members and Advisory Committee
MN	Minnesota Health Care Value Exchange (HCVE)	Board
OR	N/A	N/A
PA	Governor’s Office of Health Care Reform (GOHCR)	No formal structure; regular meetings across agencies with public/private governance structures
RI	Rhode Island Quality Institute (RIQI)	Board
VT	Vermont Blueprint for Health (Blueprint)	Advisory group, Blueprint Director reports to Commissioner of Health and consults with the Director of Health Care Reform
WA	N/A	N/A

PARTNER ROLES

The 10 profiled state quality improvement partnerships rely on the involvement of, and leadership from, a variety of state and private partners (see Appendix E). Partnerships must determine how these partners interact and decide their roles within each initiative and within the partnership structure. In some cases, the

umbrella partnership itself (including its committees or workgroups) is viewed as the lead for all projects (e.g. the Kansas Health Policy Authority, the Massachusetts HCQCC, and Pennsylvania's GOHCR). In less formal partnerships, as in Maine and in Washington, partners alternate leadership roles. In Maine, although all of the partner organizations are involved in each project, they rotate leadership duties, which consist of managing grants and timelines. The Maine Quality Forum leads the partnership's multi-payer, patient-centered medical home pilot, while Quality Counts is the lead organization for the partnership's Aligning Forces for Quality grant. The Maine Health Management Coalition chaired the Chartered Value Exchange Alliance. In some cases, formal documents outline partner roles – for example, the accord signed by each of the lead partner organizations in the Minnesota HCVE.¹²

State Agencies and Officials

State government, as a large purchaser of care, a regulator, and a convener, can enhance state quality improvement partnerships with leadership, rich data sources and strong financial incentives that can provide momentum for comprehensive public-private system improvements. In most partnerships, a state agency partner serves as the convener. State agencies and officials also provide financial support, coordinate purchasing initiatives across payers, and have the authority to require data collection and reporting. State partners also function as a watchdog to provide accountability to the public, and they can offer anti-trust protection to enable health plans to collaborate by sharing data.

The group consensus process is vital to stakeholder engagement and to furthering collaboration and trust. The state can facilitate the process in different ways, but it must maintain a balanced role as one of many equal partners. For example, rather than mandate a partnership pursue specific initiatives, a state could provide more flexibility by allowing stakeholders to set or select initiatives as a group. At the same time, if stakeholders are less decisive or struggle to reach consensus, then partners believe the state may be able to help provide needed direction. A legislative mandate can refocus partnership discussions on how to accomplish a mandated goal (e.g. data transparency), rather than getting stuck on setting a goal. Stakeholders noted that the state policy role of convener and peacemaker can conflict with the state purchasing and regulatory roles. Below are specific examples of state agencies' and officials' roles in partnerships:

- The Colorado Department of Health Care Policy and Financing led the convening and staffing of the CIVHC planning committee and oversaw workgroups created by the committee, to help develop partnership goals. The department summarized committee recommendations in a report to the governor, and as CIVHC builds its infrastructure, the state continues to manage logistics (e.g. by hiring CIVHC's director).
- The law that established the HCQCC in Massachusetts requires the partnership to create state-wide goals for quality improvement, cost containment, and reduction of racial and ethnic disparities in care.¹³ The HCQCC must produce annual reports that show its progress in achieving its goals. The law gives the HCQCC the authority both to request that third-party administrators submit data and to hold those that refuse to submit requested data publicly accountable.
- The Rhode Island Quality Institute is unique among the 10 partnerships profiled in that the private sector is the convener, and, because of statutory requirements, state officials' formal positions in the partnership have evolved over time. The Rhode Island departments of health and of business regulation are key RIQI partners. The DOH health director has been a member of the RIQI board and co-leads the RIQI's Statewide Electronic Prescribing Committee. The RIQI and DOH entered into a public-private partnership to carry out an AHRQ contract for statewide health information exchange; the DOH subcontracted with the RIQI to provide community gov-

ernance and later formally designated the RIQI as the state's Regional Health Information Organization, with responsibility for operation leadership. Rhode Island state law requires that unless specified otherwise in statute, it is a conflict of interest for state officials to serve as voting board members of an organization that receives state funds. As a result, the health insurance commissioner now serves as an ex-officio, non-voting member of the RIQI board, but state officials continue to lead subcommittees. By maintaining a balance between its roles as regulator and participant, the state is able to remain informed about the partnership's work.

- The GOHCR in Pennsylvania convenes the Chronic Care Management, Reimbursement, and Cost Reduction Commission (CCC)—one component of the governor's Prescription for Pennsylvania. The CCC has established a multi-payer partnership in which practices commit to participate in regional learning collaboratives, with the goal of implementing a hybrid of the patient-centered medical home and chronic care models and ultimately improving the delivery of chronic care. According to state and private partners, the CCC was able to attract multiple payers because the GOHCR provides needed anti-trust protection for data sharing. Additionally, the GOHCR supports the CCC with staffing, coordination of logistics—such as the flow of data between participating practices and payers—and funding of consultants, faculty, and data collection.
- The Maine Quality Forum, the legislatively authorized component of the Maine partnership, funds partnership projects and provides reporting authority. MQF conducts hospital-level performance measurement and reporting. For example, MQF analyzes health care-associated infection data and nursing sensitive indicators (NSI) that state law requires hospitals to submit to the state.¹⁴ NSI reporting in turn helps inform Maine partnership activities, such as its Aligning Forces for Quality initiative via a new AF4Q Transforming Care at the Bedside Collaborative with select hospitals in Maine.

Private Partners

The roles of private partners within the 10 state partnerships vary, depending on who has the necessary topical or technical expertise for a particular project. In addition to expertise, private partners provide funding and in-kind support. Partnerships in some states struggle to engage or lack connections to particular stakeholder groups, such as large employers, health plans, physicians, or consumers. Private partners play a vital role in reaching out to these stakeholder groups. Private partners might help by bolstering practice improvement initiatives. Specific examples of private partner roles include:

- The CEO of Physician Health Partners is an active partner and chair of the board of Colorado's CIVHC, enabling him to facilitate provider participation. Assistance with provider engagement is particularly useful for partnerships, because providers often juggle multiple quality improvement projects and requirements and may perceive partnerships' data sharing or reporting as a threat.
- The leadership and participation of Independence Blue Cross, a leading health plan in Pennsylvania, helps engage other private payers in the GOHCR's Chronic Care Commission (CCC) in Pennsylvania. With the support of Independence Blue Cross, private payers committed to provide \$13 million over three years to CCC practices for infrastructure development (survey tools, staff, data registries) and for provider attendance at learning collaboratives.
- Private partners offer health information technology expertise for the Vermont Blueprint for Health's Blueprint Integrated Pilot Program (BIPP). The Vermont Program for Quality in Health Care, a private, non-profit corporation, provides the web-based clinical tracking system and registry reports via its chronic disease registry tool (Vermont Health Record). Vermont Information

Technology Leaders, a hospital and systems integration effort, supplies the HIE network for BIPP practices, along with comprehensive data services that support practice implementation of EMR.

- The Puget Sound Health Alliance, a regional, non-profit coalition, has multiple years of experience collecting, aggregating, and reporting data using consensus measures; this expertise helps inform the Washington State Health Care Authority's efforts to implement statewide data collection and reporting.

In some cases, partnerships hire outside consultants to gather research and data, assist with convening, and provide needed objectivity and credibility. There are many examples. A consultant created the financial reform model that the Vermont Blueprint will use, and Johns Hopkins calculated the financial savings and improvement in care associated with the Rhode Island Quality Institute's Intensive Care Unit Collaborative. The Brookings Institution provides technical assistance to the Massachusetts HCQCC, regarding health plan collection of race, ethnicity, and primary language data. The recommendations will inform HCQCC's mandate for all health plans to report this data.¹⁵

FUNDING

The profiled state partnerships mostly are funded by a mix of private foundation and federal government dollars, legislative appropriations, and in-kind contributions from partners. Many partnerships access funding to conduct work through their (or a key partner's) participation in national initiatives, including the Agency for Healthcare Research and Quality's Chartered Value Exchange, the Robert Wood Johnson Foundation's Aligning Forces for Quality, and The Commonwealth Fund and AcademyHealth's State Quality Improvement Institute. It is difficult to assess partnership costs and resources given that state quality improvement partnerships often receive in-kind support through staffing, and their initiatives vary considerably. In some cases, partnerships are funded through a broader health reform initiative, making it difficult to pinpoint the resources devoted to quality improvement. Many partnerships struggle to identify sustainable funding sources for the long-term commitment needed to transform health system performance, and recent budget shortfalls have taken a toll on partnership resources. Examples of partnership funding and staffing include:

- Colorado's CIVHC received a \$51,500 planning grant from the Colorado Trust. CIVHC's planning committee recommended that the CIVHC structure add 1.5 dedicated FTE – a 0.5 FTE director and 1.0 FTE support/program staff position. An interim director was hired with the support of a grant from the Caring for Colorado Foundation;
- The Massachusetts HCQCC budget was reduced from \$1.8 million to \$1.1 million in 2009 as the result of state budget cuts;
- The Rhode Island Quality Institute has raised approximately \$7.7 million in funding since 2002, exclusive of any Agency for Healthcare Research and Quality funds. Major financial contributors include CVS/Caremark, health insurance providers, health systems, and foundations;
- The FY 2009 Vermont Blueprint for Health budget is approximately \$4.8 million. Funding comes from the state's global commitment (Medicaid program waiver savings) and the Catamount Fund, which includes Master Tobacco Settlement payments and an increase in the cigarette tax; and
- A \$1.3 million biennium budget (2007-09) and four FTEs were approved for the Washington Quality Forum. However, a hiring freeze prevented the Washington State Health Care Authority from hiring key staff for the Quality Forum, and the project was eventually terminated as part of an agency reduction as the budget shortfall grew.

SETTING PRIORITIES

Partnership leaders in the profiled states jointly create their agendas, work plans, and goals by determining the state's greatest needs for improvement, areas ripe for success, and the partnership's ability to make an impact. Project focus tends to come from a combination of sources. Leaders analyze state-specific and national data during this process. In its report to the governor, Colorado's CIVHC makes the case for its work by citing state-specific quality of care measures from both the *National Scorecard* and the Agency for Healthcare Research and Quality.¹⁶ Partnership leaders also seek input from partners and stakeholders. For example, the Massachusetts HCQCC's end-of-life care project initially stemmed from consumer interest and feedback.

Partnerships with formal structures set broad agendas through concrete work plans that describe focus areas, goals, and timelines. In states where partnerships are in statute, the legislature may set broad parameters for focus areas, but require work plans that identify specific initiatives and goals. For example:

- The executive order that created Colorado's CIVHC set broad initial tasks for the partnership related to quality improvement and cost containment. The order also called for a report with specific priorities and strategies to achieve these goals;¹⁷
- The law that established the HCQCC in Massachusetts requires the partnership to create state-wide goals for quality improvement, cost containment, and reduction of racial and ethnic disparities in care.¹⁸ The HCQCC must create a consumer website, report performance information to providers, and produce annual reports that show its progress in achieving its goals
- The Kansas Health Policy Authority's authorizing legislation tasks the partnership both with improving the health of Kansans and with developing and maintaining a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion-oriented public health strategies.¹⁹ Like the HCQCC, KHPA must submit annual reports to the legislature; the reports must include health policy agenda recommendations and health indicators (selected by the partnership) with baseline and trend data.

Partnerships' priorities overlap and are interconnected. Health and health care data feed into measurement, which provides the information partnerships need to drive improvement. For this reason, the Massachusetts HCQCC's efforts to address racial and ethnic disparities are particularly noteworthy, because they are deliberately interwoven throughout all of the partnership's initiatives. In its first annual report, the HCQCC outlines a series of strategies for quality improvement, one of which is to make sure that all of the other strategies have "targeted programs to reduce racial and ethnic disparities."²⁰ In all of its recommendations, the partnership calls for attention to the needs of racial and ethnic minority groups. For example, the HCQCC recommends consumers receive infection prevention information that is culturally sensitive and available in different languages. The partnership also recommends the planning and creation of a statewide system to improve chronic care that addresses persistent racial and ethnic disparities in the prevention and care of chronic conditions. Additionally, the HCQCC has used its authority to require that health plans collect race and ethnicity data, and that data will help inform future initiatives within this priority area.

Partnership members noted that they make a concerted effort to maintain transparency as they set priorities and execute processes and projects. The emphasis on transparency permeates not only their initiatives but their processes. Partnerships post board materials online, hold open meetings, and invite numerous stakeholders to meetings to ensure that various viewpoints are considered. Being transparent may slow down processes by allowing more partners to provide feedback, but it has its benefits. As one interviewee noted, "When efforts are public, partners are more apt to do what is in the best interest of the

patient and consumer.” Partnerships also report that sharing information and allowing feedback makes it harder for efforts to be (or appear to be) insular or self-serving. As a result, partners and communities (including the media) feel involved and invested in the partnership’s success.

STATE QUALITY IMPROVEMENT PARTNERSHIP STRATEGIC INITIATIVES

The profiled partnerships attempt to plan strategically, comprehensively, and for the long term, and to identify “quick wins” – proven initiatives that provide concrete results in a relatively short time, as well as frame and maintain interest and energy within the partnership. In terms of specific initiatives, the current foci of profiled state quality improvement partnerships range from health information exchange to health literacy. Strategic initiatives are described below, with an emphasis on the role of the partnership in moving the agenda forward (e.g. aligning, coordinating, and streamlining agendas). We emphasize partnership processes for identifying topics and partner roles, opportunities and barriers that partnerships encounter when addressing particular issues, and specific examples of some of the most common and unique partnership focus areas and initiatives. For more detailed information about profiled partnerships’ projects, please refer to websites listed in Appendix C summaries or other resources.²¹

STRATEGIES AND INITIATIVES

In their efforts to improve quality and system performance, profiled state partnerships tend to employ five broad interrelated strategies:

- Data collection, aggregation, and standardization for performance measurement;
- Public reporting and transparency of quality and/or cost data to drive accountability and improvement;
- Consumer engagement to drive change and encourage care self-management;
- Provider engagement through evidence-based practice improvement tools and guidelines; and
- Payment reform and alignment of financial incentives to encourage value-based purchasing.

In describing initiatives in detail, partners mentioned specific tools and models that fall within these strategies, such as implementation of health information technology, chronic care management, and healthcare associated infection reduction.

Without valid statewide data, the partnerships cannot measure performance, which is the foundation upon which efforts to improve quality are based. Access to data is considered critical to engaging stakeholders. Interviewees conveyed that data and performance measurement can engage and encourage providers to adopt evidence-based practices, drive value-based purchasing, and inform consumers in their efforts to select high quality care. Profiled state partnerships use existing data and resources to undertake practice improvement programs, consumer engagement activities, and payment reforms to create synergy among initiatives and move toward systemic widespread improvements.

Although there are a multitude of activities occurring in states to improve quality, the purpose of this report is to identify initiatives that are “owned” by the state quality improvement partnership, or those that are conducted by individual partners on behalf of, or in coordination with, the broader partnership, rather than individual partner initiatives. (See Table 4 for a list of focus areas and initiatives.)

The 10 profiled partnerships often take advantage of successful models in other states, which provide lessons learned along with ideas for quick wins. In Colorado, the CIVHC planning committee recommended that the partnership adopt a vision statement based on a national model – the Institute for Healthcare Improvement’s Triple Aim initiative.²² Other examples include:

- For two major initiatives, The Rhode Island Quality Institute (RIQI) has researched existing strategies and successfully replicated them. For the Rhode Island ICU Collaborative, RIQI drew from similar rapid-cycle improvement initiatives in hospitals in Michigan, Maryland, and New Jersey, which are supported by the Johns Hopkins Center for Innovation in Quality Patient Care. RIQI's Network of Care for Behavioral Health, a web-based resource for individuals with mental health and addiction issues, is part of the Trilogy Network of Care – an “interactive, single information place” where consumers and other users can go to easily access information.²³ Trilogy Network of Care is internationally recognized and exists across the U.S. State sites provide targeted resources on issues ranging from developmental disabilities to public health; and²⁴
- Based on the HCQCC's recommendations, Massachusetts has launched a demonstration program called Medical Orders for Life Sustaining Treatment (MOLST) to improve adherence to patients' wishes for care at the end of life.²⁵ MOLST is based on a successful model for communication of patients' end-of-life treatment preferences – the Physician Order for Life Sustaining Treatment processes – which are in place in at least four other states.²⁶

Below are opportunities and challenges for partnerships and specific examples of partnership initiatives within the five aforementioned strategies.

Data Collection, Aggregation, and Standardization for Performance Measurement

Data can provide a way to assess performance, track improvement over time, and report about provider and health plan performance and quality of care; thus, data can drive improvement and accountability. However, despite the opportunities that such measurement provides, states and private partners have a variety of datasets and data sources, resulting in uncoordinated data that is not used to its full potential. The health care system lacks a single source of commonly accepted and consistently applied standards to comprehensively measure quality and value.

Numerous profiled partnerships believe that using a data-driven approach helps make the case for continued involvement and investment in quality improvement, and in quality improvement partnerships. It is not surprising then that the most common focus areas among the 10 partnerships is data collection, aggregation, and performance measurement. Partnerships provide an opportunity to link and use data from a variety of state and national sources to improve the power and value of the data. Partnerships mentioned the following data sources:

- Administrative data:
 - Discharge datasets
 - Claims datasets
 - Managed care encounter datasets
- Surveys:
 - The Centers for Medicare the Medicaid Services (e.g. Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS)
 - The Leapfrog Hospital Quality and Safety Survey
 - Other state-specific surveys (e.g. Maine Health Management Coalition's hospital pharmacy safety survey).
- Clinical sources:
 - Electronic health records
 - Public health data collected routinely by all states (e.g. vital statistics)

- Assessment metrics:
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Measures mandated by state law (e.g. nursing sensitive indicators submitted to the Maine Health Data Organization)

Particularly noteworthy examples of data aggregation for performance improvement include:

- The Kansas Health Policy Authority has created a “dashboard” – a compilation of health and health care indicators related to quality, cost, access, and public health.²⁷ State statute requires KHPA to compile, analyze, and share state-specific health data and to use data to inform and drive health reform policy. The dashboard includes data culled from various state and national data sources, including the Kansas Hospital Association, the state Departments of Health and Environment and Social and Rehabilitative Services, a state trauma registry, the licensure database, the Healthcare Cost and Utilization Project, the U.S. Department of Health and Human Services, the U.S. Census Bureau, and Kids Count. Where benchmarks are available, the dashboard compares Kansas to other states and/or national standards. KHPA’s Data Consortium, a large, multi-stakeholder advisory group to the KHPA board, selected the dashboard indicators. The Data Consortium will add more indicators over time. The current dashboard includes data that are already routinely collected and have high validity and reliability; and
- The Massachusetts HCQCC, Vermont Blueprint for Health, and Maine quality improvement partnership use all-payer claims databases to inform their initiatives. The State of Vermont recently received access to an all-payer database, which the Blueprint plans to use in the evaluation of its Blueprint Integrated Pilot Program (BIPP). The partnership is flagging the records of patients at participating BIPP practices so that it can examine patients’ use of emergency departments and readmission.

Partnership participants select data sources for performance measurement based on national sources or recommendations, such as the National Quality Forum’s consensus measures or the Agency for Healthcare Research and Quality’s indicators, as well as experience in other states. Yet determining how to adjust data or set benchmarks within a state requires agreement of key stakeholder groups. As a result, interviewees believe the issue of how to appropriately report data is a local issue, whereas what to report can be taken from national standards or other states.

There are challenges and opportunities associated with performance measurement. For example, using all-payer databases to measure performance allows partnerships to shift the focus from market share to population-based approaches, thereby providing a more comprehensive understanding of quality issues in the state. Information about actual payment for care, as opposed to charges or costs, can be particularly helpful. By aggregating data, partnerships enable the data to be used to inform specific initiatives, such as healthcare associated infection prevention or ICU collaboratives. The partnerships recognize that lack of statewide data is a challenge but do not allow it to prevent them from moving forward. Although Medicare data may be unavailable, the partnerships believe their data provides an accurate, although incomplete representation that enables their initiatives to move forward.

Public Reporting to Drive Accountability and Improvement

The profiled partnerships help drive accountability and quality improvement by publicly reporting performance measurement data. As mentioned in earlier sections, transparency fuels change, and public reporting is the essence of transparency because it provides insight into provider or plan performance across patients. Public reporting can be used in a number of ways that result in quality improvement: to

help patients make decisions about care, be informed about procedures, and know what questions to ask providers; to compare costs and purchase care based on value; to enhance understanding about poor quality and underlying factors that lead to it; to help providers manage conditions; and to provide incentives to invest in and improve quality. Knowing that information will be or is public is a strong motivator for change.

Publicly reported measures may relate to patient safety, overall quality, or costs. Currently, most public reporting by the featured partnerships is about hospitals (and some physician practices). However, many profiled partnerships strive to expand public reporting to include other types of settings, such as long-term and ambulatory care.

State quality improvement partnerships have a particularly important role to play in public reporting. Nationwide, the focus on transparency and report cards has been increasing, but it remains challenging for consumers and purchasers to decide which reports to attend to and how to use them to inform their encounters with the health care system. Evidence suggests that poorly constructed and conflicting public reports on health care quality impair the ability of consumers to use the information and make appropriate decisions.²⁸ State quality improvement partnerships have the capacity to coordinate the numerous public reporting initiatives undertaken by partners in a state and help the public make sense of all of the information, either by compiling information so that consumers have a single place to turn – “one-stop shopping” – or by linking existing public reporting efforts to avoid unnecessary duplication and ensure that stakeholders know where to look for various types of information. They can also produce educational materials to assist consumers in navigating and evaluating the use of publicly reported data for decision making. Specific examples of profiled partnerships’ public reporting initiatives include:

- The Massachusetts HCQCC launched a website in 2008 called MyHealthCareOptions, which contains hospital-level cost data for 20 inpatient and 20 outpatient procedures along with quality of care ratings;²⁹
- In Minnesota, HCVE partner Minnesota Community Measurement compiled lists of quality measures currently in use for public reporting and payment incentive programs and submitted recommendations to the State Department of Health for statewide quality incentive payment system measures and methodology;³⁰ and
- In Maine, the three lead partners coordinate reporting of different measures or data and incorporate the information in their projects. MHMC reporting focuses on physician practice and hospital performance using a variety of data sources; MQF uses clinical and administrative data (claims) for hospital reporting and currently is using administrative data to analyze hospital and physician cost and quality. MHMC and MQF coordinate their claims data analysis, and their partner, Quality Counts, supports these efforts through funding and facilitation of consumer decision-making through its Aligning Forces for Quality project.

Partnerships may encounter barriers to reaching consensus on publicly reported data, including agreement on the purpose (driving improvement or accountability), what to report (issues related to data validity, reliability, risk adjustment, and priorities among the various data sources and measures), and how to report (data ownership and turf issues regarding who “owns” and reports the data). The profiled partnerships noted that national standards may assist with some of these barriers, and they also suggested that a partnership’s emphasis on transparency in all processes helps to counteract some of the concerns.

Consumer Engagement to Drive Change

The profiled partnerships conveyed the desire to involve consumers in three kinds of activities: strategic

planning, care management, and informed decision making. The partnerships engage consumers by including them and/or their advocates in internal processes. Citizens and/or advocacy groups are represented in the governance structures of the Rhode Island Quality Institute (RIQI) and the Massachusetts HCQCC. Several partnerships, such as Colorado's CIVHC and the RIQI, have subcommittees devoted to consumer engagement. The Kansas Health Policy Authority has a consumer advisory board, and Vermont's Blueprint for Health includes a community advisory group. Examples of consumer organizations that actively participate in partnerships are:

- The Colorado Consumer Health Initiative, the Colorado Multiple Sclerosis Society, the Coalition for Children's Campaign, and Family Voices are involved with Colorado's CIVHC;
- Minnesota HCVE partners include the AARP and labor unions; and
- The Rhode Island Coalition Against Domestic Violence, the Rhode Island Disability Law Center, AARP, the American Cancer Society, and the Rhode Island Parent Information Network participate in the Rhode Island Quality Institute.

Partnership consumer engagement initiatives include:

- A website created by the Kansas Health Policy Authority to promote transparency and health literacy for consumers; Kansas Health Online enables users to compare the cost and quality of health care plans and providers, and also to learn more about health policy in the state.³¹ KHPA gathered consumer feedback and worked to increase consumer awareness about the website via 17 consumer focus groups held across the state;
- The Massachusetts HCQCC has a subcommittee devoted to end of life care. The subcommittee's priorities include: the aforementioned pilot of Physician Order for Life Sustaining Treatment processes to improve adherence with patient preferences for care at the end of life in Massachusetts; ensuring that specific types of health care facilities provide terminally ill patients with formal and culturally-sensitive hospice and palliative care programs; launching a statewide, culturally competent, public educational campaign to raise awareness about end of life care options and communicating one's end of life preferences; and establishing performance measurement benchmarks for chronic and end of life care.³² The subcommittee is also involved in an "Expert Panel on End of Life Care, which is tasked with identifying best practices for end of life care based on review of care delivery and variations in care for patients with serious chronic illnesses."³³ The HCQCC's efforts to reduce re-hospitalization and improve care transitions also support quality improvement at end of life; and
- The Vermont Blueprint Integrated Pilot Program (BIPP) assesses the efficacy and sustainability of comprehensive and multi-payer reform for the general population through community-supported, patient-centered medical homes.³⁴ One component of the BIPP are local, multidisciplinary Community Care Teams, which include public health prevention specialists and help ensure patients are linked to local resources and receive coordinated care.

Despite these efforts, the partnerships are challenged in fully engaging consumers at the structural level. Although they involve consumers and seek consumer input, consumers are not yet driving forces in partnerships. Interviewees shared that quality improvement initiatives may not truly resonate with some advocates, because many consumer groups tend to focus more intently on health care access issues. Quality improvement strategies often require a technical knowledge that interviewees believe is difficult to simply and effectively communicate to consumers. Nevertheless, these partnerships remain committed to

engaging consumers and continue to look for innovative or promising practices in this area, such as the Shared Decision Making/Patient Decision Aids Demonstration (SDM/PDA) Project in Washington State. This public-private collaborative, led by the Washington State Health Care Authority, helps practice sites incorporate patient decision aid tools to help the state assess the value to patients of using a shared decision making process for certain health conditions.³⁵ Consumer engagement is a key area of the Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative, and because several state quality improvement partnerships participate in that initiative, it may offer lessons in this area in the future.

Provider Engagement through Evidence-based Practice Improvement Tools

Profiled partnerships strive to affect change in the health system by working directly with providers to implement new practices or to improve coordination to advance high quality, cost-effective care for patients. The state quality improvement partnerships offer providers various incentives to engage in practice improvement, including the credibility of state-authorized partnerships, broad-scale planning and implementation with involvement of provider representatives, and resources such as training, financial incentives, and tools to improve efficiency and patient satisfaction. Lastly, these efforts can lead to streamlined requirements of regulators and purchasers.

In addition to the potential for improvements in clinical practice, partnership members may benefit from improved working relationships with providers. Previous studies suggest that states may view quality improvement partnerships as an opportunity to shift their relationship with the provider community from that of regulator to that of collaborator.³⁶ Providers note that collaboration with states on quality improvement initiatives enables them to establish productive relationships with state officials, to shape policy, and to receive public acknowledgment of their efforts.³⁷ Examples of partnership projects include:

- Maine's partnership supported the Voluntary Practice Assessment Initiative (VPAI), a 24-month project offering free, confidential quality and patient satisfaction assessments to small, unaffiliated and certain other primary care practices in Maine. The partnership's three main partners each contributed different resources – funding and convening capability, measures, and access to information about tools and resources to help practices improve their systems of care. The partnership now supports the Maine Patient Centered Medical Home Pilot, a three-year, multi-payer pilot working with 20 primary care practices across the state to test the implementation of a medical home model;
- As part of Pennsylvania's Chronic Care Commission, the steering committee made a three-year commitment among GOHCR, participating payers, participating providers, and Improving Performance in Practice (IPIP) to adopt a learning collaborative model. GOHCR supports the faculty and expenses for a year-long learning collaborative that includes practice coaches assigned by IPIP to assist with office redesign and linking practices to community resources;
- One of Rhode Island Quality Improvement (RIQI)'s goals is to help health care providers consistently deliver care based on best known practices. For the Rhode Island ICU Collaborative, RIQI convened key partners to create and foster peer-to-peer ICU teams that share best practices, receive training from experts, rigorously collect data, and report outcomes to improve the quality of ICU care. Project partners include Quality Partners of Rhode Island and the Rhode Island Hospital Association, which monitor progress and help sustain momentum; and
- Vermont's Blueprint Communities have improved diabetes care and prevention through the aforementioned Community Care Teams, which are local multidisciplinary care support teams. The Blueprint offers provider training and incentives, expanded use of health information technology,

and evidence-based process improvement. The Blueprint contracts with the Vermont Program for Quality in Health Care to coordinate provider training and work with communities.

Despite showing promise in engaging providers, state quality improvement partnerships conveyed the need to balance competing stakeholder goals and priorities—for instance, balancing requests for provider flexibility with demand for standardization, effectively coping with time restraints on provider involvement, and weighing competing agendas of various provider interest groups (e.g. primary vs. specialty care, physicians vs. mid-level providers).

Payment Reform and Financial Incentive Alignment to Encourage Value-Based Purchasing

It is widely recognized that the U.S. health care payment structure currently does not align payment with value, and as a result, does not reward the delivery of high quality health care. According to the Commonwealth Fund, a high performing health care system would provide timely access to care, emphasize disease prevention and chronic care management, provide patient-centered care, and coordinate care across settings and over time.³⁸

Having a routine source of primary care is associated with better individual and population health and lower costs.³⁹ However, financing for this approach is challenging in a system that typically reimburses providers for visits and procedures. Many medical home initiatives reimburse providers through additional payments for administrative time beyond direct care, in order to coordinate care. Although there are differing definitions of a medical home, most definitions that states use reflect the core primary care values of a personal provider who offers first contact care or a point of entry for new problems, ongoing care over time, comprehensive care, and coordination of care across an individual's conditions, providers, and settings.⁴⁰ Financial incentives and supports for medical home providers could make primary care a more attractive choice for physicians and help ensure the viability of the primary care system in some areas of the country.

Multi-payer payment reform is a critical strategy for state quality improvement partnerships, yet it may be the most challenging. Although there are both public and private sector initiatives working toward payment reform, they tend to be isolated efforts. Providers may participate in a variety of different pay-for-performance initiatives sponsored by different payers. State quality improvement partnerships provide an opportunity to streamline and conduct broad-scale payment reform initiatives across public and private sector payers. Examples from profiled partnerships include:

- One element of Minnesota's state health reform is payment reform. "Baskets of care" bundle payments for services to treat certain health conditions or episodes of care in order to offer incentives to provider collaboration and to the delivery of high-quality, efficient care.⁴¹ The State Department of Health has contracted with HCVE partner ISCI to facilitate the development of these baskets of care.⁴² In addition, the Quality Incentive Payment System will offer providers additional payment based on their performance on quality measures;⁴³
- The Chronic Care Commission (CCC) in Pennsylvania, organized within the GOHCR, is supporting implementation of a combination of the chronic care model and the patient-centered medical home model throughout Pennsylvania. The CCC established a multi-payer partnership with support and funding by all large payers, convened and supervised by GOHCR. Practices sign up for and make a three-year commitment to participate in regional learning collaboratives and make infrastructure and care delivery changes. In return, they receive enhanced payments to their current contractual payments; and

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- Vermont's Blueprint Integrated Pilot Program (BIPP) includes financial reform components. Medicaid and the state's three commercial payers use a common payment structure, and participating providers receive enhanced payment for achieving National Committee on Quality Assurance patient-centered medical home standards. Additionally, payment for the aforementioned BIPP care coordination teams is shared by payers, which provide \$250,000 for each team of five people. As part of the pilot, the Blueprint also subsidizes Medicaid's pay for performance program.

Despite broad recognition of the need for payment reform, partnerships struggle with perverse payment incentives and capturing savings that result from improvements. The ability of partnerships to address payment reform also depends in part on which stakeholders are engaged, as well as their history of collaboration and competition. In some partnerships, lack of engagement among large employers or health plans can stymie efforts. Payment reform also heavily depends on valid data and measurement. Without strategies to measure performance, it is not possible to structure systems to pay for value.

Although state partnerships have prioritized the five strategies discussed above, partnership representatives articulated a struggle to move beyond discrete activities to a level of systemic planning and implementation, and to remain mission-focused rather than project-focused. They also noted that state quality improvement partnerships differ in scope and breadth, and that the number of strategies and focus areas are not indicative of the quality of effort: leaders recognized the importance of focusing and making progress on particular areas of greatest need and interest. More is not necessarily better, given limited resources.

TABLE 4: STATE QUALITY IMPROVEMENT PARTNERSHIP PROJECT STRATEGIES AND FOCUS AREAS

Current Project Strategies / Focus Areas	CO (CIVHC)	KS (KHPA)	ME (MHMC, MQF, QC)	MA (HCQCC)	MIN (HCVE)	OR (N/A)*	PA (GOHCR)	RI (RIQI)	WA (N/A)**	VT (Blueprint)
Data collection, aggregation, and standardization										
Data collection	•	•	•	•	•	•	•	•	•	•
Performance measurement	•	•	•	•	•	•	•		•	•
Health information technology	•	•	•		•			•		•
Public reporting										
Public reporting of quality or cost data		•	•	•	•	•	•		•	•
Consumer engagement										
Consumer engagement (e.g. committees, websites)	•	•	•	•			•	•		
Health literacy		•	•							•
End of life care				•						•
Behavioral health								•		•
Provider engagement through evidence-based practice improvement										
Provider engagement through evidence-based practice improvement	•	•	•		•		•	•		•
Avoidable hospitalizations		•		•			•			•
Chronic care		•	•	•	•		•			•
Healthcare associated infections			•	•			•	•	•	
Payment reform and alignment of financial incentives										
Payment reform	•	•	•	•	•				•	
Medical home	•	•	•		•	•	•			•
Cost containment	•	•	•	•		•				•

*Based on existing efforts among partners and work outlined in pending state legislation, HB 2009.

** Based on originally proposed work of Washington Quality Forum.

ASSESSING PARTNERSHIP VALUE AND ACCOMPLISHMENTS

When asked what added value the profiled partnerships bring to their states, interviewees unanimously agreed that the partnerships increase transparency and foster collaboration, communication, and information-sharing among key stakeholders. They also shared many examples of accomplishments that have resulted from partner collaboration. Yet, because of factors discussed below, it can be challenging at times to assess the impact of the partnerships.

INTRINSIC VALUE OF PARTNERSHIPS

Interviewees consistently reported that public-private collaboration across all sectors of health care (payers, regulators, providers, policymakers, consumers) is by its nature worthwhile and necessary, because no single stakeholder group can transform the health system alone. Having a diverse group of stakeholders enables a spectrum of perspectives, skill sets, resources, and areas of expertise to be represented and inform quality improvement decision-making and projects. Interviewees cited the need for a blended approach to quality improvement – one that includes legislative, regulatory, and voluntary strategies to bring about systemic change. By involving partners with responsibilities and experience in each of these areas, partnerships facilitate the change process by fostering communication and collaboration among participants who might otherwise avoid, oppose, or compete with each other. And, as one interviewee noted, stakeholder engagement tends to snowball: “So many stakeholders are involved that others want to participate.” Last, partnerships provide a way for states to streamline quality improvement efforts so that they are efficient and not duplicative.

ACCOMPLISHMENTS

Quality improvement partnerships cite a variety of both process and project accomplishments (see Table 5). Process accomplishments include improving relationships, sustaining stakeholder engagement, increasing communication among stakeholders or partners, developing infrastructure, and consensus-building. For example:

- For eight years, the Rhode Island Quality Institute has sustained CEO-level leader engagement and participation in its governance and initiatives;
- Among the newest partnerships, Colorado’s CIVHC has created a governance structure, established several workgroups, and hired a director. Minnesota’s HCVE created a governance structure and established partner responsibilities;
- The Massachusetts HCQCC and Kansas Health Policy Authority brought partners together and selected consensus quality measures for collection and/or reporting in their states; and
- The Vermont Blueprint for Health, Pennsylvania’s GOHCR, and the Maine quality improvement partnership have made it possible for public and private payers to agree on and implement uniform payment methodologies as part of their successfully launched medical home initiatives.

Project accomplishments include launching initiatives, collecting quality and cost data, publishing reports and data, facilitating the implementation of policies or passage of laws, gaining recognition by national or federal programs, and documenting improvements. The Minnesota HCVE partners and the Pennsylvania GOHCR advised and participated in the development and implementation of health reform legislation. The Maine partnership of Quality Counts, the Maine Health Management Coalition, and the Maine Quality Forum participates in the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative; both the Maine partnership and the Minnesota HCVE have been designated as Chartered Value

Exchanges by the Agency for Healthcare Research and Quality. The Rhode Island Quality Institute's ICU Collaborative has seen significant financial returns and reductions in healthcare associated infections.

TABLE 5: STATE QUALITY IMPROVEMENT PARTNERSHIP ACCOMPLISHMENTS TO DATE

Partnership	Significant Accomplishments to Date
CO (CIVHC)	<ul style="list-style-type: none"> Infrastructure building: established governance structure, hired CEO, and formed five workgroups (aligning benefits and finances, consumer engagement, improving health care delivery, data sharing for performance measurement, and end of life care). Completed a report to the Governor's Office in December 2008 that lays out the progress, recommendations, goals and strategies for the workgroups.
KS (KHPA)	<ul style="list-style-type: none"> Established a continuous Medicaid Program Review/Transformation process to systematically improve quality and efficiency, reduce costs, and find additional revenues – resulting in a 357-page data review. Achieved agreement on and started publicly reporting indicators on quality, access, cost, and public health, including several HEDIS measures of Medicaid managed care organizations. Improved relationship with CMS by addressing and correcting payment issues from past audits and management reviews and by creating a Medicaid integrity unit to be the facilitator of quality and integrity efforts across multiple state agencies. Created a consumer website for comparison of health care plan and provider cost and quality. Started developing a technology infrastructure (Data Analytic Interface) to allow the integrated analysis of Medicaid, state employee, and private insurance data, based on episodes of treatment, disease management, predictive modeling, and the measure of cost and outcome effectiveness.
ME (MHMC, MQF, QC)	<ul style="list-style-type: none"> Selected as one of 14 grantees nationally by the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative. Launched implementation of Maine's patient-centered medical home pilot in January 2009. Awarded status as a Chartered Value Exchange. Selected (as Maine CVE) to participate in CMS Electronic Health Record Demonstration (Wave II), which CMS has since cancelled.
MA (HCQCC)	<ul style="list-style-type: none"> Released its first annual report in April 2008, which identifies specific strategies designed to improve health care quality while containing costs. Established an all-payer claims database via regulations in 2007 and 2008. Launched a consumer website that includes hospital-level cost and quality information, built on an agreed upon set of principles for the selection of measures. Anchored work in measurement, specifically reporting from the Commonwealth of Massachusetts, the Commonwealth Fund State Scorecard, Dartmouth Atlas, RAND, National Quality Forum, and other validated work.
MN (HCVE)	<ul style="list-style-type: none"> Awarded status as a Chartered Value Exchange. Advised and participated in the development of state health reform legislation.
OR (N/A)	<ul style="list-style-type: none"> Oregon hopes to build on the accomplishments of potential QI partners, including: A Chronic Disease Clearinghouse pilot led by the Oregon Health Care Quality Corporation, Oregon Asthma Network, and Oregon Diabetes Coalition to inform the statewide development and collection of outpatient primary care, evidence-based measures for improvement in the treatment of asthma, cardiovascular disease, diabetes, and depression. Created a website with AHRQ hospital QI indicators.

TABLE 5: STATE QUALITY IMPROVEMENT PARTNERSHIP ACCOMPLISHMENTS TO DATE, CONTINUED

Partnership	Significant Accomplishments to Date
PA (GOHCR)	<ul style="list-style-type: none"> • Established statewide, multi-payer partnership on chronic care disease management. • Collecting information on outcomes. Outcome data on individual learning collaborative sites will be shared among the collaborative. • Implemented new laws to provide transparency in health quality and protect patients from health facility-acquired infections, which in the first six months helped result in a 7.8 percent decrease in hospital-acquired infections (HAI) and 300 fewer HAI-related deaths than the year before. • Changed scope of practice laws to allow physicians' assistants, certified nurse practitioners, clinical nurse specialists, and dental hygienists to practice to the full extent of their education and training. • Developing a statewide health information exchange. • Implemented payment reform, including the Medicaid Program no longer paying for "Never Events."
RI (RIQI)	<ul style="list-style-type: none"> • Rhode Island ranks second in the nation in e-prescribing. • Awarded a formal designation from the State as Rhode Island's Regional Health Information Organization. • Sustained CEO-level leader engagement and collaboration for eight years. • Realized a 59 percent reduction in central line infections, with the baseline compared to the latest 12 months. • Realized a 2 percent reduction in ventilator associated pneumonia, with the baseline compared to the last 12 months. • ICU financial returns approximately five times the cost of the ICU Collaborative project. <p>Management of the Rhode Island Network of Care for Behavioral Health.</p>
VT (Blueprint)	<ul style="list-style-type: none"> • Six Blueprint Communities have implemented improved care and prevention for diabetes, hypertension, and asthma. • Selected three communities to participate in the Blueprint Integrated Pilot Program (BIPP), which incorporates age- and gender-appropriate health maintenance, as well as chronic disease. • BIPP has started operations in two of three communities, with the third to start in the summer of 2009.
WA (N/A)	<ul style="list-style-type: none"> • Several of the Puget Sound Health Alliance's accomplishments will help inform efforts to implement statewide data collection and reporting. For example: • Two Community Checkup reports have been published (www.wacommunitycheckup.org). • Selected as one of 14 grantees nationally by the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative. • Awarded status as a Chartered Value Exchange. • In addition, the Alliance and State continue to partner on broader health reform initiatives.

IMPACT

Despite significant accomplishments, partnership leaders noted the difficulty in quantifying the extent to which their work has had an impact, although they can measure trends. For example, the launch of a

consumer website is an accomplishment, yet its impact on the everyday experiences of patients is unclear. Do consumers use the information to help make informed decisions? Uncertainty about partnership impact stems from several sources:

- In most cases, the partnerships' relative youth means that it is simply too soon to assess impact.
- It is difficult to attribute causality to a partnership's work, because there are so many factors simultaneously affecting the health system, including both national and state level quality improvement efforts. Separating the work of partnerships from statewide health reform is particularly difficult. In states where partnerships are part of larger health reform, such as the HCQCC in Massachusetts or the GOHCR in Pennsylvania, is quality improvement the result of health reform or the partnership's efforts to support and facilitate reform?
- The role of culture is challenging to ascertain. Is there something about states that have a history or culture of collaboration that enables them to form quality partnerships and also provide high quality care? Is there something about states that rank high on national scorecards that enables collaboration?
- The interrelated nature of quality improvement initiatives complicates the process of assessing the impact of a partnership as a whole versus the contributions that individual partners make on their own.
- Quantifying (and substantiating) prevented problems, such as medical errors, is problematic. It is difficult to measure what does not happen.

Despite the challenges associated with assessing impact, and in some cases recognizing structural challenges to creating change through voluntary collaborative processes, the profiled partnerships remain committed to the ongoing process of fine-tuning their goals and outcome measures, based on new knowledge and experience, to ensure that they realize their capacity and capture the true value of their contributions to sustain stakeholder and funder engagement.

KEY THEMES AND LESSONS

The importance of three factors emerged throughout interviews and discussions with members of state quality improvement partnerships: leadership, transparency, and sustainability. Each of these areas is vital to the success of a partnership, and partnerships identified challenges and lessons learned associated with each one.

LEADERSHIP

Interviewees shared that high CEO-level leaders must be involved in partnerships at the onset as members of governance structures and as conduits between the partnership and stakeholders. Involving people with clout conveys the importance of the partnership's efforts. As one interviewee stated, [Having high-level leaders "shows that the partnership's work is going somewhere and it's not just a planning effort."] Interviewees' specific lessons learned include:

- Ensure governing boards represent high-level leaders who can set the direction of their organizations; quality improvement must be a "top-down" priority because information does not translate or transfer from the "bottom up;"
- Select initial, core leaders based on individual strengths rather than out of professional obligation. Seek out the thought leaders – individuals who are well-respected, influential, and committed to quality improvement – rather than people who happen to represent particular stakeholder groups;
- Thought leaders not only attract participants and help to grow the partnership but also push the partnership to aim higher and think and act in innovative ways. Thought leaders help partnerships set "stretch goals" for improvement that seem (and may well be) impossibly high, but that draw attention to the need for improvement and energize participants to achieve them. For example, the Massachusetts HCQCC envisions that, by June 30, 2012, Massachusetts will consistently rank as the state achieving the highest levels of performance in quality care;
- For partnerships with formal structures, dedication to the partnership's formal mission sustains CEO-level engagement; leaders remain focused on the higher purpose of health system reform for quality improvement. As high level leaders, they are able to move beyond discussion of what needs to be done and can focus on using their leverage to get the work done; and
- Although thought leaders often consider it a privilege and form of service to learn from and teach others, formally recognizing leaders' contributions helps sustain momentum.

TRANSPARENCY

Partnerships and their leaders are able to bring in new stakeholders in part because they ensure their processes and projects are open to the public and will accept differing viewpoints. Everyone has an opportunity to contribute and help shape the partnership's work. The challenge of bringing in multiple perspectives is that stakeholders often have differing priorities and sometimes seek different outcomes, Legislators, providers, advocates, regulators, and payers all have their own interests, needs, and goals. Some partnerships place particular emphasis on including vocal or opinionated stakeholder groups to ensure that the partnership considers opposing ideas and strong viewpoints. For example, RIQI included advocacy organizations with strong concerns about patient privacy in its discussions about HIT and HIE privacy. Profiled partnerships shared the following lessons learned:

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- Hold open, public meetings and post meeting dates and materials online, where they are easily accessible;
 - Ensure that partners and stakeholders review draft materials and have the opportunity to provide feedback;
 - Encourage and incorporate constructive criticism, but do not let it derail progress toward achieving the mission; and
 - Help partners find common ground – areas where their priorities and desired outcomes overlap. If needed, bring participants back to the main focus: either the formal mission statement or the broader mutual goal of improved quality of care and system performance.

Partnerships must continuously balance the need and desire for public input with the need to keep work moving forward. By remaining transparent in their processes, partnerships and their products and discussions are stronger and more inclusive.

SUSTAINABILITY

Interviewees consistently described the importance of obtaining and ensuring adequate partnership funding and support. Partners shared that quality improvement partnerships are long-term commitments that take time to develop and produce results. They therefore need long-term funding and stakeholder engagement. For partnerships with formal structures, staff members provide critical programmatic support and help engage and foster relationships with stakeholders, yet these partnerships face insufficient staff support and funding, especially given difficult state economic situations. Although many partners provide in-kind support and donate their time, the economic downturn has similarly affected state agencies' and other entities' ability to contribute financially to partnerships. The 10 partnerships identified several lessons learned regarding sustainability:

- Inventory quality improvement resources and initiatives in the state before creating new ones. Unnecessary expense, duplication, and conflict may be avoided by augmenting existing structures and coalitions;
- Use a data-driven approach to make the case for projects and continued funding and to sustain the interest and involvement of stakeholders often affected by the data collected, shared, and/or reported by partnerships. Although a lack of Medicare data poses a challenge for states that strive to create and analyze information from all-payer databases, it should not stifle initiatives;
- Focus on value and identify opportunities to contain costs (or “blunt the curve of growth”) as part of quality initiatives. With budget shortfalls and rising health care expenditures, most everyone can agree that initiatives that shed light on how to contain costs while improving quality of care are worthwhile investments;
- Be politically savvy about state health reform. State health care reform can provide the necessary momentum for collaboration around quality improvement, but unpopular state politics or reform efforts can stymie partnership efforts if stakeholders perceive the partnership to be an extension of larger partisan battles;
- Avoid partisan politics and commit to nonpartisanship. It may help garner widespread support and solidify a partnership's place as a neutral, trusted entity;

- Help investors see the benefit of continued investment by bringing them to meetings or events that demonstrate benefits; and
- Develop concrete action plans with specific goals and timelines to promote accountability, keep partnerships on task, and provide a way of assessing and reporting the partnership's progress and accomplishments to current and potential funders and participants.

CONCLUSION

The key factors, policies, and practices that influence the quality improvement partnerships in 10 states offer insights for achieving systemic improvement in health care quality and performance. Although the profiled state quality improvement partnerships have differing origins, structures, and priorities, they all rely on strong thought leaders, commit to transparent processes and projects, and strive for long-term sustainability. Moreover, the partnerships share a dedication to multi-stakeholder and public-private collaboration. They believe that improving the health system depends on the input and participation of differing perspectives and the ability to draw from countless skills sets and areas of expertise.

It is daunting to create a broad-based state partnership that promotes multi-pronged, strategic, systemic improvements in the health care system, particularly when faced with an economic downturn. Partners must simultaneously determine the partnership's appropriate role, identify sustainable funding, ensure the partnership has the authority and credibility necessary to transform the current health care service delivery system, and determine what can be accomplished at the state level. Nevertheless, in an era of increased attention to health reform nationally and an awareness of the need to improve health care system quality and value, state quality improvement partnerships' efforts have the potential to move the state and federal quality agendas forward and merit continued attention.

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APPENDICES

APPENDIX A: ADVISORY GROUP MEMBERS

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Joshua Cutler, M.D.

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Katharine London

Former Executive Director, Massachusetts Health Care Quality and Cost Council

Cal Ludeman

Acting Commissioner, Minnesota Department of Human Services

Janet D. Olszewski

Director, Michigan Department of Community Health

APPENDIX B: MEETING PARTICIPANTS

**STATE PARTNERSHIPS TO IMPROVE QUALITY: UNDERSTANDING CRITICAL SUCCESS FACTORS
FEBRUARY 10-11, 2009**
Laura Adams

President and CEO, Rhode Island Quality Institute

JudyAnn Bigby, M.D.

Secretary, Massachusetts Executive Office of Health and Human Services

Amy Boutwell, M.D.

Content Director, Lead Faculty, Reducing Rehospitalizations Initiative, Institute for Healthcare Improvement (Massachusetts)

Jim Chase

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Joel Weissman, Ph.D.

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APPENDIX C: STATE QUALITY IMPROVEMENT PARTNERSHIP SUMMARIES

CENTER FOR IMPROVING VALUE IN HEALTH CARE (COLORADO)

Origin and mission

The Center for Improving Value in Health Care (CIVHC) was established by an executive order signed by Governor Ritter on February 13, 2008, as part of the “Building Blocks to Health Care Reform” plan. CIVHC was created to establish an interdisciplinary, multi-stakeholder entity to identify and pursue strategies for quality improvement and cost containment. Led by the Colorado Department of Health Care Policy and Financing, CIVHC brings consumers, businesses, health care providers, insurance companies, and state agencies together to develop long-term strategies to identify, integrate, implement, and evaluate quality improvement strategies. The goals are to ensure a better value for the \$30 billion spent on health care each year in Colorado and to improve the service delivery systems, which will improve quality and drive down costs.

CIVHC’s vision is to optimize the health care system by “improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations,” as identified by the Triple Aim initiative, which was created by the Institute for Healthcare Improvement. To avoid duplication of effort, CIVHC intends to coordinate the various organizations and initiatives that involve cost containment and quality improvement.

Governance

A planning committee of health care providers, advocates, quality experts, and state officials was formed in January 2008 to make decisions about governance structure and scope of work. This group met monthly to discuss quality improvement initiatives underway throughout the state and to identify opportunities for increased collaboration among these initiatives. The group, which also addressed the areas in which Colorado health care is in greatest need of improved quality outcomes, was charged with making recommendations to the Department of Health Care Policy and Financing.

In April, 2008 the Department received a \$51,500 grant from The Colorado Trust to contract with JSI Research and Training Institute to help research both quality improvement efforts in other states and options for Colorado to explore, and to help facilitate planning committee meetings.

In its December 2008 report to the governor, the planning committee (under the Department’s leadership) recommended that the CIVHC Board consist of 7 to 15 members “who are highly influential in the business, civic and health care communities, are passionate about improving value in health care, and possess a strategic perspective.” The planning committee also recommended that the CIVHC structure add 1.5 dedicated FTE – a 0.5 FTE director and 1.0 FTE support/program staff position.

In April 2009, the governor appointed 17 community members and 5 ex-officio members to the board and named the first interim director of CIVHC, whose position is supported by a grant from the Caring for Colorado Foundation. Board members represent a variety of entities, including state agencies and departments (e.g. Division of Insurance, Department of Health Care Policy and Financing, Department of Human Services, Department of Public Health and Environment); CMS; health plans; providers, such as hospitals, community health centers, clinics, and health care systems; HIT organizations; consumers; and foundations. Chairs of the CIVHC’s five workgroups also serve as ex-officio members of the Board.

Activities and accomplishments

- Infrastructure building: developed a mission, vision, and strategic imperative; established a governance structure; hired a director; formed five workgroups (aligning benefits and finances, consumer engagement, improving health care delivery, data sharing for performance measurement, and end of life care); and appointed board members and board chair.
- Completed a Report to the Office of Governor in December 2008, which lays out the progress, recommendations, and goals and strategies for CIVHC and its workgroups.
- Selected to participate in The Commonwealth Fund and AcademyHealth's State Quality Improvement Institute – an intensive, competitively selected effort to help states plan and implement concrete action plans to improve performance across targeted quality indicators.

Website

CIVHC: <http://www.colorado.gov/cs/Satellite?c=Page&cid=1216634433584&pagename=HCPF%2FHCPFLayout>

KANSAS HEALTH POLICY AUTHORITY

Origin and mission

The Kansas Health Policy Authority was established in 2005 with the passage of Senate Bill 272 in the Kansas Legislature. The bill established KHPA as a state agency within the executive branch of state government (KSA 75-7401, et seq.). Its general charge is to improve the health of Kansans and to develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion-oriented public health strategies.

Before 2005, the state of Kansas purchased health care and health coverage for state employees and various other populations through myriad programs and agencies. A primary reason for consolidating those programs into a single agency was to leverage the state's combined purchasing power to achieve greater efficiency and cost savings. The Executive Director of KHPA has the responsibility and statutory authority to oversee the Medicaid and Children's Health Insurance (CHIP) programs, the State Employee Health Benefits Plan, and State Workers Compensation, as well as the health care data responsibilities of the former Health Care Data Governing Board.

Governance

The bill called for forming a 16-member board of directors to govern the agency, including nine voting members appointed by the governor, speaker of the house, and senate president, as well as seven non-voting, ex-officio members. The seven ex-officio members include the secretaries of Health and Environment, Social and Rehabilitation Services, Administration, and Aging; the director of the Department of Health and Environment; the state insurance commissioner; and the executive director. In 2008, the Kansas Legislature designated the state education commissioner as an eighth ex-officio member. The board provides independent oversight and policymaking decisions for the management and operation of KHPA.

Activities and accomplishments

In 2006, KHPA's board chartered the Data Consortium, a public advisory group (to the Board) that makes recommendations regarding health data and policy (e.g. reporting standards and access to health

information). The Data Consortium includes four workgroups (access, affordability and sustainability, quality and efficiency, and health and wellness) tasked with selecting measures, prioritizing measures for public reporting, identifying needed and available data for reports, coordinating initiatives across agencies, and determining how to develop and sustain routine reporting. Consensus measures are prioritized based on a tiered system that accounts for the availability and integrity of existing data. The Data Consortium has achieved agreement on quality indicators, and the baseline data on each indicator is posted for public viewing.

The governor and the 2007 legislature charged KHPA with developing a comprehensive health reform plan. That plan consisted of 21 policy recommendations. Legislation in 2008 (SB 81 2008) codified some but not all of the original 21 priority areas requested by KHPA. Current focus areas include medical home, a Community Health Record initiative, transparency, health literacy, and a crosscutting Medicaid transformation. KHPA is addressing all focus areas, but its priorities are driven by data trends. To address transparency, KHPA has created a website that enables consumers to compare the cost and quality of health care plans and providers (<http://www.kansashealthonline.org/>). KHPA also has been involved in the process to define a Kansas medical home passed as part of health reform.

Website

KHPA: www.khpa.ks.gov

MAINE QI PARTNERSHIP

Origin and mission

Maine has created a partnership among three equal organizations and coalitions to focus on quality improvement – the Maine Quality Forum (MQF), the Maine Health Management Coalition (MHMC), and Quality Counts (QC).

The Maine Quality Forum, which is the legislatively authorized component of the partnership, was established in 2003 by Gov. John Baldacci and the Maine Legislature as part of the Dirigo Health Reform. MQF has been charged with collecting research, promoting best practices, collecting and publishing comparative quality data, promoting electronic technology, promoting healthy lifestyles, and reporting to consumers and the legislature.

Quality Counts, established in 2006, is committed to working together across organizations and communities to improve health care systems and outcomes with the people of Maine. Quality Counts coordinates existing but disparate efforts across the state that support local, patient-centered, and coordinated systems of care, as well as the resources that support them. Its goals are to improve health status, promote consistent delivery of high quality care, improve access to health care, and contain health care costs.

In existence since 1993, the Maine Health Management Coalition is an employer-led partnership among multiple stakeholders (including MaineCare or Medicaid). The Coalition works collaboratively to maximize improvement in the value of health care services delivered to MHMC members' employees and dependents. MHMC has three public reporting initiatives that report quality data on hospitals and primary care practices, using mostly publicly available data that is organized and reported in a manner usable for employers and consumers. Through its Employee Activation Initiative, MHMC helps member organizations develop and share tools to communicate information about quality health care to employees. MHMC also

has a multi-stakeholder workgroup that is designing a payment reform model to pilot. The model will build on previous work commissioned by the Maine Quality Forum that analyzed unwarranted variation.

Governance

This partnership of partnerships has come together to support a range of quality initiatives in the state, and together with the state's emerging regional health information organization is an AHRQ-recognized Chartered Value Exchange for Maine, though it has no formal mission or governance structure. Each of the three organizations and coalitions has its own mission, board, and structure, representing diverse stakeholders. The three organizations have cross-populated advisory groups and developed collaborative leadership on initiatives (e.g. the Aligning Forces for Quality initiative's executive leadership team). Although different funding and governance structures make it challenging to share projects, the partners have effectively supported a range of improvement activities, and they coordinate and communicate in a concerted effort to avoid duplicating efforts.

Activities and accomplishments

- Maine's partnership is focused on the areas of medical home, practice improvement, public reporting, and consumer engagement. MHMC reporting focuses on the physician, practice, and hospital performance levels, using a variety of data sources; MQF uses clinical and administrative (claims) data for hospital reporting and is using administrative data to analyze hospital and physician cost and quality. MQF is transitioning from Maine-designated measures to NCQA/Bridges to Excellence measures. Quality Counts focuses on promoting multi-stakeholder collaboration and the spread of quality improvement learning.
- The Voluntary Practice Assessment Initiative (VPAI) is a 24-month project offering free, confidential quality and patient satisfaction assessments to small, unaffiliated, and certain other primary care practices in Maine. It is funded by MQF, uses MHMC measures, and will provide access to the QC Learning Community (which offers information about tools and resources to help practices improve their systems of care).
- The three organizations together were awarded a grant from the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative. QC serves as the lead organization for the grant, and representatives from QC, MHMC, and MQF serve on the executive leadership team.
- Maine was awarded status as a Chartered Value Exchange by the Agency for Healthcare Research and Quality (AHRQ) in January 2008. MHMC convened the Maine CVE Alliance, which includes MQF and QC, as well as HealthInfoNet, Maine's regional health information exchange. As part of the CVE, MQF led the successful application for the CMS demonstration initiative to promote the adoption of electronic health records. The project's intent was to reward the delivery of high quality care supported by the adoption and use of electronic health records in physician practices. (The project has since cancelled by CMS.)
- The partners are leading a three-year, patient-centered, multi-payer medical home pilot. The first phase of the pilot (planning) was completed at the end of 2008. The second phase (implementation) began in January 2009, with solicitation of applications.

Websites

Maine Health Management Coalition: <http://www.mhmc.info/>; www.mehmc.org

Maine Quality Forum: <http://www.mainequalityforum.gov/>

Quality Counts: <http://www.mainequalitycounts.org/>

MASSACHUSETTS HEALTH CARE QUALITY AND COST COUNCIL (HCQCC)

Origin and mission

The Massachusetts Health Care Quality and Cost Council is mandated under Massachusetts General Law Chapter 6A and was established by Chapter 58 of the Acts of 2006. The council's mission is to develop and coordinate the implementation of health care quality improvement goals that are intended to both lower or contain the growth in health care costs and improve the quality of care, including reductions in racial and ethnic health disparities. The council's vision is that by June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in care that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

The council is mandated:

- To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care;
- To demonstrate progress toward achieving those goals; and
- To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy makers, and the general public.

The council is within, but not subject to control of, the Massachusetts Executive Office of Health and Human Services. It reports annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals.

Governance

The council is made up of 16 members that include a diverse group of individuals with a broad array of expertise in the public and private sectors. Subcommittees currently include Chronic Care, Communications and Transparency, Cost Containment, Governance, Patient Safety, and End of Life. The council receives input and advice from a 30-member advisory committee that includes representation from consumers, business, labor, health care providers, and health plans. Through its membership, outreach, and subcommittees, it interfaces across health care in the state.

The council's budget was reduced from \$1.8 million to \$1.1 million in 2009 as a result of state budget cuts.

Activities and accomplishments

The council is mobilizing stakeholders to address priority areas and is highly inclusive in all considerations. The council anchors its work in measurement, specifically reporting from the Commonwealth of Massachusetts, the Commonwealth Fund State Scorecard, Dartmouth Atlas, RAND, National Quality Forum, and other validated work. Specific accomplishments to date include:

- Release of its first annual report in April 2008, which identifies specific strategies designed to improve health care quality while containing costs (http://www.mass.gov/lhqcc/docs/annual_report.pdf);
- Establishment of an all-payer claims database via regulations in 2007 and 2008 (see 129 CMR 2.00: Uniform Reporting System for Health Care Claims Data Sets and 129 CMR 3:00: Disclosure of Health Care Claims Data);

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- Launch of a consumer website (<http://hcqcc.hcf.state.ma.us>) based on extensive market research. Site includes hospital-level cost (for 20 inpatient and 20 outpatient procedures) and quality information built on an agreed upon set of principles for the selection of measures;
 - Public reporting of serious reportable events by hospital; and
 - Early selection as a state to participate in a four-year, multi-state initiative funded by the Commonwealth Fund and led by the Institute for Healthcare Improvement to reduce avoidable hospitalizations across the state.

Next steps

The council is working to:

- Develop a roadmap (by September 2009) to achieve cost containment goals that health care will increase only by inflation rates by July 1, 2012 and that Massachusetts will rank first on The Commonwealth Fund Commission on a High Performance Health System Scorecard;
- Drive the institution of specific activities, including a statewide campaign by spring of 2009 to improve care at the end of life so that it is respectful of patients' wishes and includes effective resource utilization;
- Expand its focus on patient safety to non-hospital environments;
- Publicly report hospital-wide mortality (by January 2010);
- Update and expand the public reporting of quality and cost information; and
- Build consumer understanding of the quality and cost website and how to use it.

Website

Massachusetts HCQCC: <http://www.mass.gov/?pageID=hqcchomepage&L=1&L0=Home&sid=lhqcc>

MINNESOTA HEALTH CARE VALUE EXCHANGE

Origin and mission

In November 2008, five Minnesota organizations signed an accord to form an alliance called The Minnesota Health Care Value Exchange. The alliance was established to support HIT; quality improvement and measurement; price transparency and public reporting; incentives to promote high-quality, efficient care; and consumer engagement and education. The five partner organizations comprising the Minnesota Health Care Value Exchange are:

- Buyers Health Care Action Group (BHCAG), a non-profit coalition of large private and public employers working to redirect the focus of the health care system to optimal health and value;
- Institute for Clinical Systems Improvement (ICSI), a non-profit organization that brings together medical groups, hospitals, health plans, employers, and other groups to provide patient-centered and value-driven care to patients in Minnesota and surrounding states;

- MN Community Measurement (MNCM), a community-based, non-profit organization that works to accelerate the improvement of health through measurement and public reporting of health care performance;
- Smart Buy Alliance, an affiliation of private, public, group, union, and individual health care purchasers working to ensure that health care reforms focus on improving health and health care delivery for all Minnesotans. It includes Minnesota Management & Budget (state employees) and Human Services (Medicaid, SCHIP, and MinnesotaCare); and
- Stratis Health, a non-profit organization that leads collaboration and innovation in health care quality and safety, serves as a trusted expert in facilitating improvement for people and communities, and is the state's Quality Improvement Organization (QIO).

Governance

Although each of the five member organizations has its own separate governance structure, the Minnesota Health Care Value Exchange has a board with one representative from each organization. The Minnesota Health Care Value Exchange elects members to fulfill specific responsibilities, including convener of meetings and logistics (Buyers Health Care Action Group), AHRQ contactor (Smart Buy), finance representative (to be determined), and Medicare data steward (Stratis).

Activities and accomplishments

The Minnesota Health Care Value Exchange is working to coordinate health reform activities and build upon the quality improvement, performance measurement, and public reporting activities already occurring in the community. Priority areas include care model redesign, purchasing redesign, payment reform, consumer engagement initiatives, and electronic medical record and personal health record implementation. The Minnesota Health Care Value Exchange received Chartered Value Exchange designation from Department of Health and Human Services Secretary Mike Leavitt in March 2008.

The alliance's activities directly relate to state health care reform legislation signed into law in May 2008 (Senate File 3780, Senate File 2942, House File 3149, and House File 1812). The goal is to move toward achieving quality, affordable, accessible health care for all Minnesotans. The legislation includes "health care home" criteria; e-prescribing; the use of encounter data to establish peer groupings of providers based on quality and efficiency; as well as payment reform, quality measurement, and cost/quality transparency. Minnesota Health Care Value Exchange is the coordinating body for members' work on state health reform legislation, including:

- The Minnesota Quality Reporting and Incentive Payment System,
- Health care home support and development,
- Bundles of care measurement and payment, and
- Provider peer grouping by cost and quality.

The Value Exchange also is developing funding and other support for care re-design projects (e.g. Depression Care Improvement).

Member organizations have partnered in the past for Quality Care and Rewarding Excellence (QCare), an initiative created by the governor's executive order in 2006. QCare aims to gather, analyze, and distribute data on health and health care in Minnesota to guide health care reform in the state. QCare identified certain focus areas (diabetic care, public health, hospital "never events") in which to improve care, in ad-

dition to consensus goals for the state to achieve by certain dates. The QCare group included physicians, hospital leaders, members of the legislature, and businesses, as well as state agencies.

Websites

BHCAG: www.bhcag.com

ICSI: www.icsi.org

MNCM: www.mnhealthcare.org

Smart Buy Alliance: www.smartbuyalliance.com

Stratis Health: www.stratishealth.org

OREGON QI PARTNERSHIP

Origin and Mission

Oregon has an informal public/private partnership to coordinate, communicate, and implement a range of quality initiatives in the state. The partnership has no formal name, but legislation (House Bill 2009) to formalize the partnership as the “Oregon Quality Care Institute” is under consideration, per recommendations to the governor and legislature from the Oregon Health Fund Board’s health reform plan. As of May 2009, the bill was in the Ways and Means Committee with a “Do-Pass” recommendation. The following organizations are involved:

- The Oregon Health Policy Commission (OHPC) was enacted in 2003 (HB 3653) and is administered through the Office for Oregon Health Policy & Research (OHPR). The OHPC is comprised of 10 commission members who represent the state’s congressional districts and 4 non-voting legislators who serve as advisory members to the OHPC. The OHPC collects and evaluates data on Oregon’s health care system and provides information and policy recommendations to the governor and legislature;
- The Oregon Health Fund Board (OHFB), developed out of the Oregon Health Policy Commission, was chartered under the 2007 Healthy Oregon Act (SB 329) to develop a comprehensive plan to ensure affordable quality health care for every Oregonian. OHFB is comprised of seven citizen Board members appointed by the governor and confirmed by the Oregon Senate;
- The Oregon Patient Safety Commission is a semi-independent state agency that partners with public and private stakeholders to improve safety in Oregon’s health care delivery system; and
- The Oregon Health Care Quality Corporation (Quality Corp) is a non-profit 501 (c)(3) multi-stakeholder organization that brings together public and private stakeholders in a neutral forum to identify and implement strategic projects for improving health care through community based activities. The Quality Corp is the state’s Robert Wood Johnson Foundation Aligning Forces for Quality grantee.

Governance

The partnership does not have a separate governance structure, but the partners frequently participate as board members of each other’s organizations. For example, the Office of Health Policy and Research, which administers the Oregon Health Policy Commission, also staffs the Oregon Health Fund Board. OHPR’s administrator sits on the Public Employee Benefits Board and the board of The Oregon Health Care Quality Corporation. There is a close connection with the Medicaid and public health divisions in

both the Quality Corporation and the Patient Safety Commission. Each partner has funding for its initiatives; the partnership does not have separate funding at this time, pending legislative authorization.

Activities and accomplishments

The partnership does not have its own mission but has worked collaboratively on:

- Electronic health records,
- Quality data reporting and transparency,
- Value-based purchasing,
- Patient safety and engagement, and
- Coordinated state agency quality action plan (in conjunction with AcademyHealth's Quality Improvement Institute).

Oregon hopes to build on partners' previous and continuing efforts, including:

- A Chronic Disease Clearinghouse pilot led by the Quality Corp, Oregon Asthma Network, Oregon Diabetes Coalition, and Department of Human Services, which is providing information for statewide development and collection of outpatient primary care evidence-based measures. The goal is to improve the treatment of asthma, cardiovascular disease, diabetes, and depression (led by the Quality Corp);
- OHPR's creation of a website with AHRQ hospital quality indicators (<http://www.oregon.gov/OHPPR/HQ/index.shtml>). OHPR is working to accomplish quality reporting via cost data (insurance), health care charges data (claims), and crosswalk indicators, which are currently posted online;
- The OHFB created a new special focus workgroup on health equities. Hospital data sets will now report racial/ethnic data and will add ambulatory surgical data.

Websites

Q-Corp: <http://www.q-corp.org/>

OHFB: <http://www.oregon.gov/OHPPR/HFB/>

OHPR: <http://www.oregon.gov/OHPPR/>

OPSC: <http://www.oregon.gov/OPSC/index.shtml>

PENNSYLVANIA GOVERNOR'S OFFICE OF HEALTH CARE REFORM (GOHCR)

Origin and mission

Pennsylvania's partnership began with an HRSA state planning grant that established the HRSA State Plan Advisory Council. A consensus that emerged from that process led to the Prescription for Pennsylvania (Rx for PA), an initiative that is administered through the Governor's Office of Health Care Reform. Rx for PA is Gov. Edward G. Rendell's comprehensive health care reform initiative to address the access, affordability, and quality of health care in the commonwealth. Rx for PA is a set of integrated strategies to eliminate inefficiencies in the health care system, better manage chronic conditions, eliminate health facility acquired infections, enact common sense insurance reforms, and offer access to affordable health care insurance for the uninsured. Rx for PA aims to ensure that every Pennsylvanian has access to quality health care.

State officials are working through Rx for PA to align quality initiatives of various state agencies, including the Pennsylvania Health Care Cost Containment Council (PHC4); the of Health, Public Welfare, and Insurance; and an independent state agency, the Patient Safety Authority (PSA).

Governance

Although the Governor's Office of Health Care Reform has no formal governance structure, it coordinates the efforts of several state agencies that have public-private governance structures, including PHC4, PSA, and the Chronic Care Management, Reimbursement and Cost Containment Commission (CCC). Regular cabinet meetings are held to coordinate internally. Funding is provided through the state budget process.

Activities and accomplishments

The CCC was created under Rx for PA through executive order by Gov. Rendell in May 2007 to improve how Pennsylvanians with chronic disease receive health care. The commission is responsible for developing a strategic plan to effectively manage chronic disease across the state. The strategic plan includes recommendations for the informational, technological, and reimbursement infrastructure needed to support the implementation of a combination of the chronic care model and the patient-centered medical home (PCMH) model throughout Pennsylvania, which will improve quality outcomes and cost effective treatments for patients with chronic diseases.

The Chronic Care Commission has established a multi-payer partnership, with support and funding by all large payers, convened and supervised by OHCR. Practices sign up for and make a three-year commitment to participate in regional learning collaboratives that are implementing patient-centered medical home and chronic care models. Practices are making infrastructure and care delivery changes, including:

- Attending quarterly learning collaborative meetings for training on how to transform their delivery of care to conform to the patient-centered medical home and chronic care models;
- Hiring staff (certified registered nurse practitioners, case managers, health educators) to create care teams that will coordinate and facilitate care and provide education and self-management skills training;
- Using a practice coach to facilitate transformation of the practice and assist with preparation for National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PCC®-PCMHTM) recognition;
- Implementing a patient registry with embedded, secure, encrypted e-mail capability for enhanced patient-practice communication, as well as the ability to generate both care gap reminders to patients and monthly reports of performance metrics for monitoring;
- Implementing open access scheduling to improve access to care; and
- Agreeing to apply for and achieve NCQA PCC®-PCMHTM recognition in the first year.

Payers support the program financially by making payments to support infrastructure development and staffing. The model has participating payers make payments proportionate to the 1099 revenue received from the payer in relation to total revenue received by the practice. This model allows for fair participation by various coverage models (HMO, PPO, POS) and for commercial, managed Medicaid, and Medicare Advantage products. The Governor's Office annually collects and validates revenue and periodically

generates statements to payers to initiate the reimbursement process as milestones are achieved. Health plans are also paying for health coaches in proportion to revenue.

Other related accomplishments of Rx for PA include:

- New laws to provide transparency in health quality and to protect patients from health facility-acquired infections, which in the first six months helped result in a 7.8 percent decrease in hospital-acquired infections and 300 fewer hospital acquired infection-related deaths than the year before;
- Changes in scope of practice laws to allow physicians' assistants, certified nurse practitioners, clinical nurse specialists, and dental hygienists to practice to the full extent of their education and training;
- Developing a statewide health information exchange; and
- Payment reform, including the Medicaid program no longer paying for "never events."

Website

Pennsylvania Governor's Office of Health Care Reform: <http://www.state.pa.us/>

RHODE ISLAND QUALITY INSTITUTE

Origin and mission

In 2001, former Rhode Island Attorney General and now United States Sen. Sheldon Whitehouse brought together the highest ranking leaders of health care stakeholders, including hospitals, health insurers, state government, physicians, employers, nurses, academia, Rhode Island's Quality Improvement Organization (QIO), and professional organizations. He challenged the group to work collaboratively to dramatically improve the quality, safety, and value of health care in Rhode Island. The Rhode Island Quality Institute (RIQI) was formally launched in May 2002 as an independent 501 (c)(3) organization. The RIQI aims to:

- Demonstrate how the health care system can be improved through collaborative innovation;
- Foster connectivity between the health care team and the patient;
- Increase accuracy, responsiveness, and effectiveness in health care by using technology to standardize, streamline, and accelerate the retrieval and delivery of patient data statewide;
- Help the health care team consistently deliver care that is based on best-known practices; and
- Create a system that inspires and rewards improved professional performance.

Governance

RIQI is governed by a 24-member board of directors made up of influential leaders in health care who represent health systems, health insurance providers, a Medicaid health plan, the business community, providers, consumer advocates, Quality Partners of Rhode Island (the state's QIO), and both current and former state officials (two of whom are non-voting, ex-officio members). Sixteen committees help guide

the work of RIQI. The board-level committees include Executive, RIQI Operations, Regional Health Information Organization (RHIO), Oversight, Nominating and Governance, Audit and Compliance, and Public Affairs. Project committees include Statewide e-Prescribing, Health IT Adoption, Clinical IT Leadership, Policy and Legal, Technical Solutions, Consumer Advisory, Rhode Island ICU Collaborative Leadership, and Steering Committees for Rhode Island Health Information Exchange and Rhode Island Network of Care.

RIQI has raised approximately \$7.7 million in funding, exclusive of any Agency for Healthcare Research and Quality (AHRQ) funds. Major financial contributors include CVS/Caremark, health insurance providers, health systems, and foundations.

Activities and accomplishments

RIQI's main activities include statewide health information exchange, electronic medical record adoption, electronic prescribing, intensive care unit improvement, and management of the Rhode Island Network of Care for Behavioral Health. In 2004, RIQI approached the Rhode Island Department of Health (DOH) to pursue an AHRQ contract for statewide HIE. The state and RIQI entered into a public-private partnership, and the State was awarded the grant. The DOH subcontracted with the RIQI to provide community governance, and, in 2007, it formally designated the RIQI as Rhode Island's Regional Health Information Organization. As the RHIO, RIQI will provide the necessary operation leadership and administer and operate *currentcare*, Rhode Island's HIE (www.currentcareri.org).

The Rhode Island ICU Collaborative is a partnership of the RIQI, Quality Partners of Rhode Island, Hospital Association of Rhode Island, the state's acute care hospitals, Blue Cross and Blue Shield of Rhode Island, and UnitedHealthcare of New England. The collaborative, which includes every adult ICU in every hospital in the state, involves peer-to-peer ICU teams sharing strategies and best practices, guidance and training from experts (e.g. Johns Hopkins University), project management and support, and rigorous data collection/outcomes reporting.

In conjunction with a group of community partners, RIQI also manages the Rhode Island Network of Care for Behavioral Health, a web-based resource for those struggling with mental health and addiction issues either personally or within their families (<http://rhodeisland.networkofcare.org/mh/home/index.cfm>). This virtual community and resource directory, available in 14 different languages, offers confidential web access; comprehensive behavioral health information; support and advocacy for children, adults, and families; and a customized Rhode Island program and service directory. This initiative is part of the Trilogy Network of Care, which was selected as a finalist in the "Stockholm Challenge," an international competition that honors information and communication technologies that show convincing benefits to people and communities.

Website

RIQI: www.riqi.org

VERMONT BLUEPRINT FOR HEALTH (BLUEPRINT)

Origin and mission

The State of Vermont, under the leadership of its governor, legislature and the bipartisan Health Care Reform Commission, has established a program called the Blueprint for Health. The Blueprint is guiding

a comprehensive and statewide process of transformation designed to reduce the health and economic impact of the most common chronic conditions, and to focus on their prevention. The state's strong commitment is demonstrated in the 2006 statutory codification of the Blueprint as the state's plan for changing health care delivery. Further legislation in 2007 and 2008 strengthened the involvement of private insurance carriers. The annual state budget supports the health care transformation process, along with expanded use of health information technology and the development of a statewide health information exchange network.

The Blueprint is a vision, a plan, and a statewide partnership to improve the state's health care system and the health of Vermonters. It aims to shift the focus of the health care system to preventing illness and complications. The Blueprint started as an initiative to create a chronic care infrastructure and uniform model for providing chronic care in Vermont (its original pilot sites focused on diabetes). It has developed into a statewide health reform project that spans agencies and addresses the general population. The Blueprint quality improvement components include improved health maintenance, prevention, and chronic care management for a general population; financial reform that aligns incentives with health care goals; expanding the use of health information technology supported by an information exchange infrastructure; and a reporting and evaluation infrastructure that supports individual patient care, population management, quality improvement, and program evaluation.

Governance

The director of the Vermont Blueprint reports to the commissioner of health and is responsible for implementing the program. The director coordinates the program across all levels of state government and with non-government partners. Blueprint goals are defined by the governor and legislation. The Blueprint is expected to work across agencies, sectors of society, and public-private partnerships. The director works with an Executive Committee, and a Planning & Evaluation Committee, as well as with advisory workgroups as needed.

The FY 2009 Blueprint budget is about \$4.8 million. The FY 2010 budget is just more than \$4 million. Funding comes from the state's global commitment (Medicaid program waiver savings) and the Cata-mont Fund (which includes Master Tobacco Settlement payments and an increase in cigarette tax).

Activities and accomplishments

Over the last three years, six Blueprint communities (authorized under Act 191) have implemented improved diabetes care and prevention via provider training and incentives, expanded use of health information technology, evidence-based process improvements, statewide self-management workshops, and statewide support for community activation and prevention programs.

Legislation (Act 71, 2007 and Act 204, 2008) authorized the Blueprint to select three communities to participate in the Blueprint Integrated Pilot Program (BIPP) to assess the efficacy and sustainability of comprehensive, multi-payer reform for a general population. Blueprint supports participating pilot practices by helping them operate a patient-centered medical home (PCMH). A multidisciplinary Community Care Team provides care support for the PCMHs in a community. BIPP also includes an infrastructure for multidimensional evaluation that encompasses measures of clinical processes, health status, and health care patterns and expenditures (via claims data from a multi-payer database populated by information from all insurers and third party administrators), as well as return on investment and financial impact.

BIPP practices receive:

- Enhanced payment for meeting National Committee for Quality Assurance (NCQA) PCMH standards.
- Local multidisciplinary care support teams called Community Care Teams (CCTs), which include public health prevention specialists.
- A web-based clinical tracking system.
- Health information exchange between electronic medical records, hospital data sources, and a web-based clinical tracking system.

BIPP Partners include:

- Private and public payers who share the costs of CCTs and have a common payment structure based on a practice's NCQA PCMH score.
- Vermont Information Technology Leaders (VITL), a hospital and systems integration effort that supplies the HIE network and provides comprehensive data services that help practices implement EMRs.
- Vermont Program for Quality in Health Care (VPQHC), a private, non-profit corporation formed in 1988 with which the Blueprint has contracted to coordinate provider training and work with communities. VPQHC also provides registry reports via the Vermont Health Record (its chronic disease registry tool) and the web-based clinical tracking system.

Website

Vermont Blueprint for Health: <http://healthvermont.gov/blueprint.aspx>

WASHINGTON STATE QI PARTNERSHIP

Background

In May 2007, the Washington State Legislature passed health reform legislation (Chapter 259, Laws of 2007, SB 5930), calling for payment reform, a shared decision-making demonstration project, and the establishment of the Washington State Quality Forum within the Washington State Health Care Authority. The HCA is a state agency that oversees seven health care programs. The legislation was introduced by Gov. Chris Gregoire as a result of recommendations in a 2007 Blue Ribbon Commission report. The law directs the Quality Forum to collaborate with other partners to:

- Collect and disseminate research about health care quality, evidence-based medicine, and patient safety to promote best practices;
- Coordinate health care quality data collection among state health care purchasing agencies;
- Adopt measures to assess and compare health care cost and quality and provider performance;

- Identify and distribute information about variations in clinical practice patterns; and
- Create an annual quality report with information about clinical practice patterns for purchasers, providers, insurers, and policymakers.

The legislation specifically references the Puget Sound Health Alliance as a partner for the Quality Forum. The alliance is a non-profit organization focused on three objectives: advance transparency of variation in performance to drive system improvement; align purchaser and payer incentives for quality and efficiency in provider reimbursement and co-sponsor collaborative activities designed to stimulate quality improvement. The alliance was established in December 2004 in response to the King County Health Advisory Task Force's recommendations. A regional partnership, the alliance has built a strong multi-stakeholder "alliance among patients, doctors, hospitals, employers, union trusts, health plans and others to promote health and improve quality." The alliance's 21-member board of directors is made up of representatives from public and private employers, union trusts, consumers, health care delivery systems, health professionals, and health plans. Alliance partners agree to share administrative data to produce public reports (Community Checkup Reports, described below) measuring the quality of care provided in the region. The HCA has been and remains an alliance partner, as evidenced, for example, by its representation on the board of directors.

Activities

Unfortunately, a budget shortfall has stalled efforts to develop the Quality Forum. A \$1.3 million biennium budget (2007-09) and four FTEs were approved for the Quality Forum. An August 2008 hiring freeze prevented the Quality Forum from hiring key staff, and in November 2008 the HCA terminated the project as part of an agency reduction as the budget shortfall grew. HCA is reviewing ways in which it can realize statewide data collection and support the database of quality and performance information that the Alliance has amassed over the years. One key data-driven project of the Alliance is the Community Checkup Report, a free resource that enables users to compare health care provided at medical groups, doctors' offices and hospitals across five counties (<http://www.wacommunitycheckup.org>). Reports were published in both January and November 2008 and include 21 ambulatory performance measures related to diabetes, heart disease, depression, low back pain, generic drugs, appropriate use of antibiotics, and preventive care. The reports also include 48 hospital performance measures in a number of quality and safety areas.

Per the 2007 legislation, the HCA is leading the Shared Decision Making/Patient Decision Aids (SDM/PDA) demonstration project to evaluate and promote the effective use of tools that help patients exercise shared decision making about treatment options for preference-sensitive health conditions. The alliance is one of several organizations involved in the project. Practices selected for the SDM/PDA project will incorporate patient decision aid tools into clinical practice, provide practitioner training and support, and submit evaluation data about the value of applying a shared decision making process for certain health conditions to their patients.

Websites

Puget Sound Health Alliance: <http://www.pugetsoundhealthalliance.org/>

Washington State Health Care Authority: <http://www.hca.wa.gov/>

APPENDIX D: INTERVIEW PROTOCOL

This interview, part of a NASHP project funded by The Commonwealth Fund, examines state-level inter-agency agendas for improving health care quality, including partnerships with the private sector. Through this project, NASHP aims to uncover the key factors that contribute to success in designing quality partnerships, and to gather and broadly disseminate information summarizing these factors, as well as the lessons learned about existing efforts in leading states with quality improvement partnerships.

Note: Comments will not be attributed to individuals and you will have an opportunity to review a draft report.

1. How would you describe your partnership?
 - a. Is it an umbrella partnership of various other partnerships?
2. When was your partnership established and by whom?
 - a. What brought the partnership together (e.g. sentinel event, shared idea)?
 - b. Was the partnership's establishment part of a state mandate?
 - c. Is the partnership part of a broad state health reform?
3. What are the goals or purpose of your partnership?
4. What is the state's role in your partnership (e.g. funder, technical assistance, legislative authorization, convener, advisor, etc)?
5. What are the partnership's areas of focus (e.g. HIT and data sharing; rewarding high performance (performance based payment); transparency and reporting; patient-centered, preventive, and chronic care initiatives, collecting and analyzing data to evaluate and benchmark performance)?
 - a. In which kinds of activity is your partnership currently engaged?
 - b. How do you prioritize these focus areas and the corresponding activities and projects?
 - c. Is your partnership involved in any efforts to increase transparency about cost and quality? Do you have a dedicated webpage where you make cost, quality, and other data available to consumers?
6. What sectors do you target as the audience for your activities (e.g. providers, legislators, purchasers, consumers, etc.)? Are your quality improvement activities focused on change at the institutional or individual provider level (e.g. providing data at facility vs. practitioner level)?
7. What type of governance structure does your partnership have (e.g. board of directors, steering committee)?
 - a. What sectors are represented as members of the governance structure (e.g. public and/or private sector purchasers and/or providers, and regulators, consumers, advocates, legislators), and why? Are representatives of the medical system included? Is the QIO included? Major payers? Insurance carriers?
8. Do you partner with any additional entities in other ways? Who are the partners and what role does each play (e.g. participation in workgroups or project committees)?
 - a. Are these partners from the public sector, private sector, or both?
 - b. With which state agencies do you work?
 - c. Are consumers represented by any of your partners?

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9. What resources does your partnership have (e.g. dedicated staffing, data processing), and what are your funding sources (e.g. foundations, state dollars, etc)?
 - a. Does your partnership have dedicated funding?
 - b. What is your budget, and how long will your current funding sustain your efforts?
 10. What are some characteristics of a good partner?
 11. How would you describe the status of communication and collaboration between state agencies and the private sector in your state with respect to health care issues? Has this changed as the result of your partnership?
 12. What has been your partnership's progress to date?
 - a. What are your significant accomplishments?
 - b. How do you assess whether the partnership has made an impact?
 - c. What lessons have you learned that could help other state partnerships?
 13. Has the value of your partnership changed over time? How?
 - a. Have you re-evaluated its value over time?
 - b. How have partners' roles changed as their priorities and projects have changed?
 14. What have been some barriers to achieving the partnership's goals? What challenges remain?
 15. What would make your partnership stronger (e.g. any federal or state-level change)?
 16. To which states do you look for best practices in QI partnerships?
 17. Who else from your state do you think we should interview?

APPENDIX E: PARTNERSHIP PARTICIPANTS

Based on interviews with partnerships, NASHP compiled the following table to list many of the public and private partners that actively participate in each of the profiled partnerships. These partners participate in a variety of ways, including serving on governance structures or work committees, attending meetings, reviewing materials, providing programmatic or technical expertise or assistance, and funding initiatives.

Partnership	Public Partners	Private Partners
CO (CIVHC)	Department of Regulatory Agencies – Division of Insurance, Department of Human Services, Department of Health Care Policy and Financing, Department of Public Health and Environment, CMS, Veterans Affairs, and the University of Colorado.	Business Group on Health, Bridges to Excellence, Chartered Value Exchange, private payers, Colorado Association of Health Plans, hospital association and medical society, providers, QIO, four large health foundations, Colorado Patient Safety Coalition, health systems (Denver Health), consumer organizations (Colorado Consumer Health Initiative, Colorado Multiple Sclerosis Society, Colorado Children’s Campaign, and Family Voices), integrated delivery networks, HIT organizations (e.g. CORHIO).
KS (KHPA)	Medicaid, State Employee Health Benefits Plan, Kansas Insurance Department, Department of Health and Environment, Department of Social and Rehabilitation Services, Department of Administration and Aging, and Department of Education.	Kansas Foundation for Medical Care, Kansas Hospital Association, private insurance carriers, self-insured employers, consumer advocacy groups (e.g. AARP), a collaborative of physicians and hospitals, professional societies (e.g. AAFP, AAP), and the safety net association.
ME (MHMC, MQF, QC)	Maine Quality Forum, State Employees Health Commission, Medicaid; Maine Municipal Employees Health Trust and other public purchasers, Maine Center for Disease Control and Prevention, and the University of Maine System.	Maine Health Management Coalition (large purchasers, providers, employers, health plans, Maine Education Association Benefits Trust); Quality Counts (large employers, consumers, the Maine Center for Public Health, and others); and HealthInfoNet.
MA (HCQCC)	Massachusetts Division of Health Care Finance and Policy, Division of Insurance, Department of Public Health, Executive Office for Administration and Finance, Executive Office of Health and Human Services, Group Insurance Commission, Office of the Inspector General, Office of the State Auditor, and Office of the Attorney General.	Massachusetts Medicaid Policy Institute, Institute for Healthcare Improvement, QIO, National Association of Insurance and Financial Advisors, Massachusetts Association of Health Underwriters, EHealth collaborative, consumers (e.g. Partnership for Health Care Excellence), business, labor, health care providers, and health plans.

Partnership	Public Partners	Private Partners
MN (HCVE)	Large and small public employers, the Minnesota Management & Budget (state employees), the Department of Human Services (Medicaid, SCHIP, and MinnesotaCare) via the Smart Buy Alliance.	Buyers Health Care Action Group (large private employers); Institute for Clinical Systems Improvement (medical groups, hospitals, health plans, employers, and others); Minnesota Community Measurement; Smart Buy Alliance (private purchasers); Stratis Health (physicians and nurses, health delivery organizations including acute and long-term care, health plans, and consumers and consumer advocates); small and large unions; and AARP.
OR (N/A)	Office for Oregon Health Policy & Research, the Oregon Health Fund Board, Oregon Public Employees' Benefits Board, and Oregon Patient Safety Commission.	The Oregon Health Care Quality Corporation (health plans, provider associations, hospitals, purchasers, consumer organizations, and others).
PA (OHCR)	Office of Health Care Reform, Health Care Cost Containment Council, Patient Safety Authority, and Departments of Health, Public Welfare, and Insurance.	The Pittsburgh Regional Health Initiative, medical academies, large employers, consumers, unions, large payers (IBC, Aetna, etc.), and providers (hospital systems, practitioners, and provider organizations).
RI (RIQI)	Department of Health, Office of the Health Insurance Commissioner, Office of Health and Human Services, State Division of Information Technology, and Office of the Lieutenant Governor.	Integrated delivery networks (Lifespan and Care New England), hospitals, large payers (BCBS of Rhode Island, UnitedHealthcare of New England, Neighborhood Health Plan of Rhode Island), provider groups (hospital association and medical society), Quality Partners of Rhode Island (QIO), corporate funders, community health centers, Rhode Island Business Group on Health, Mental Health Association of Rhode Island, consumer and advocacy organizations (e.g. Rhode Island Disability Law Center, AARP, Rhode Island Coalition Against Domestic Violence, American Cancer Society, Rhode Island Parent Information Network), academia, and many other community partners.
VT (Blueprint)	Medicaid; Medicare; governor; legislature; Agency of Human Services; Departments of Health, Transportation, Finance, and Treasury; Vermont State Employees Association; University of Vermont College of Medicine; Area Health Education Centers.	Vermont Program for Quality in Health Care; three commercial payers; pilot practices; Vermont Information Technology Leaders; hospitals; Vermont Child Health Improvement Program; Vermont Medical Society; and Vermont Chapters of AAP, AAFP, ACP, and ACC.
WA (N/A)	Washington State Health Care Authority, Department of Social and Health Services, Department of Health, Office of Financial Management, Department of Labor and Industries, Agency Medical Directors' Group, Office of the Commissioner, and county governments	Puget Sound Health Alliance (consumers, physicians, hospitals, large employers, union trusts, regional health plans) and the Washington Health Foundation.