

REGIONAL HEALTH IMPROVEMENT COLLABORATIVES



Essential Elements for Successful Healthcare Reform

ROOTS

A MODERN AMERICAN SOCIAL MOVEMENT TAKES SHAPE: THE VIEW FROM THE GROUND

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We have assembled this edition of **R&OFS** because we wanted to capture a modern American social movement—the healthcare quality improvement, or value, revolution—and the critical role that a network of Regional Health Improvement Collaboratives has and will continue to play in advancing change.

Over the last two decades, early champions of healthcare reform recognized that the healthcare system to which they entrusted their lives and those of their families and employees, or in which they provided or paid for care, was vastly underperforming. This awareness caused committed physicians, insurers, employers, and administrators to assemble in coalition across the United States. Much was at stake, from preventing patient deaths and disabilities, to retaining a workforce frustrated by institutional barriers to excellence, to preserving local businesses crippled by mounting healthcare expenses.

The result was a network of Regional Health Improvement Collaboratives (Collaboratives) seeking to effect change on a monumental scale, to transform healthcare delivery, payment and information systems. These Collaboratives pursued change from the bottom up, acting collectively and deliberately in different locales to increase the quality and reduce the cost of care. They represented a new kind of local coalition formed to tackle quality engineering at the frontline, regional performance measurement and public reporting, and the prevention and better management of disease—in new and ambitious demonstrations. In so doing, they have proven the power of multi-stakeholder regional approaches for testing new models of care, measuring performance, and shining a light on improvement opportunities.

This edition of **R&OFS** reviews the history of Regional Health Improvement Collaboratives—setting the stage for understanding their current status and their potential for advancing healthcare reform. It considers their unique structure and function—features that are essential to their success in advancing regional solutions to health care’s problems. To demonstrate the similarities and differences among Collaboratives, and to describe more fully how several Collaboratives assumed roles in measuring health system performance, facilitating payment and delivery system reform, providing training and assistance to providers, educating consumers, and managing chronic disease, this edition provides profiles of a select group of Collaboratives, their history, governance and leadership.

The Roots of Revolution

The healthcare quality revolution had its roots in two different concerns that eventually converged. The first involved the high cost of health care, which increasingly alarmed the business community, and the second revolved around the recognition among academics and clinicians that American health care was shockingly unsafe and unreliable.

The escalation in healthcare costs accelerated in the late 1980s and early 1990s, peaking in 2002, in spite of efforts like managed care and Certificate of Need requirements to curb growth. And the rapid consolidation of the healthcare industry through mergers and consolidations was actually increasing the cost of care in areas where competition declined, even though consolidation had originally been hailed as an ‘efficiencies and cost-cutting’ measure. Regional Business Groups on Health formed, as purchasers of care sought to contain runaway cost.

Meanwhile, during the 1990s, and early 2000s, other regional coalitions involving multiple stakeholders were also forming to address serious quality and safety concerns. Influential thought leaders like Drs. Jack Wennberg, Lucian Leape, Don Berwick, Atul Gawande, and Robert Wachter, and others like Michael Millenson and Rosemary Gibson presented credible and compelling evidence of the serious potential for harm in healthcare practices. In response, new institutions such as the Institute for Health Care Delivery Research with Dr. Brent James, the Institute for Healthcare Improvement led by Dr. Don Berwick, the Institute for Clinical Systems Improvement shaped by Dr. Gordon Mosser, the National Patient Safety Foundation and the federal Agency for Healthcare Research and Quality under Dr. John Eisenberg were formed to advance quality and safety. Prestigious research centers such as the Institute of Medicine, The Commonwealth Fund, RAND, Reuters, and Milliman presented further data quantifying and assessing the financial consequences of our failures in safety, quality and efficiency.

A New Vision Emerges

The convergence occurred in the later 1990s when thought leaders like Dr. Ken Kizer at the Veterans Administration, Paul O'Neill at the Pittsburgh Regional Health Initiative and, eventually, Michael Porter of the Harvard Business School linked cost containment concerns to quality improvement solutions, declaring that higher quality would lead to lower cost. The objective was to perfect patient care, remove waste, error and suboptimal clinical practices, guaranteeing that every dollar spent on health care produced value. O'Neill brought industrial engineering principles to the frontline of care; Kizer began the quality transformation of the Veterans Administration health systems; Dr. Ed Wagner tackled chronic disease management—the highest-cost problem in health care.

The vision—that providing the very best evidence-based care every time to every patient, without waste or error, would contain cost and save lives and reduce disability—was compelling. Ultimately, providers of health care would compete on value (the best outcomes of care at the lowest cost), and be rewarded for performance excellence through patient volume and payment. The vision was advanced by physicians, economists, and business leaders; it caught the attention of the media, Congressional representatives and policy makers, and patients. Meanwhile, credible researchers kept measuring the human and financial costs of bad care. All this produced a new sense of urgency to fix the breaks in the system. A revolution in thinking about health care depended on the promise provided by a new vision.

Regional Collaboratives proliferated, focusing on different value-driven activities that included: a) public reporting and measurement systems to provide transparency for comparison shopping, rewards for excellence, and performance improvement; b) quality improvement at the frontline through methods like Lean; and c) disease management. Some Collaboratives evolved spontaneously; others evolved within existing coalitions, such as business groups on health or Medicare quality improvement organizations. In 2006, Collaboratives with different foci recognized their common objectives and aspirations and formed the Network for Regional Healthcare Improvement (NRHI). The Aligning Forces for Quality and the Chartered Value Exchange networks also emerged at roughly the same time, further uniting various Collaboratives in a common cause.

Demonstration after demonstration proved that quality improvement methods could reduce cost, as well as error, harm, and waste. Unfortunately, under the current payment system, these efforts at cost containment and quality improvement—to open a real “market” for health care, to demonstrate the value of information exchange, to perfect clinical practice—did not reward those who actually provide and deliver care. This clearly inhibited progress. However, with Collaboratives active throughout the U.S. realizing new visions for value, the conditions for social revolution took root. Progress toward quality and value in health care accelerated, resulting in the incorporation in the Patient Protection and Affordable Care Act of 2010 of many quality and safety provisions, as well as payment reform measures.

TWO CRITICAL DECADES

IN THE REGIONAL HEALTH REFORM MOVEMENT

1988

Jack Wennberg, MD, founds Dartmouth Institute for Health Policy and Clinical Practice to investigate variations in cost, outcomes, and service utilization

1989

Pacific Business Group on Health forms

1990

James Reason's *Human Error* introduces modern error analysis to medicine

1995

Massachusetts Health Quality Partners founded

1997

National Patient Safety Foundation established
Ed Wagner, MD, develops Chronic Care Model, advancing care management
Pittsburgh Regional Health Initiative founded

1999

Institute of Medicine publishes *To Err is Human*, estimating that 44,000 - 98,000 Americans die needlessly each year from medical error
Agency for Healthcare Research and Quality created
Michael Millenson publishes *Demanding Medical Excellence* revealing flaws in U.S. health care

2005

Four emerging Regional Health Improvement Collaboratives meet in Minnesota to discuss quality improvement opportunities
Minnesota Community Measurement incorporated
Steven Spear publishes *Fixing Healthcare From the Inside* in Harvard Business Review

2006

California HealthCare Foundation invites broader group of quality improvement collaboratives to meet for two days in San Francisco; 80 leaders from 40 organizations in 17 states represented
Network for Regional Healthcare Improvement formally established with funding from the Robert Wood Johnson Foundation, the California HealthCare Foundation, and Jewish Healthcare Foundation
Robert Wood Johnson Foundation launches Aligning Forces for Quality, supporting regional collaboratives

2007

Commonwealth Fund publishes *Multinational Comparisons of Health Systems*; awakens U.S. to high cost and low quality of U.S. health care
The Network for Regional Healthcare Improvement held a one-day, invitation-only national Summit on Creating Payment Systems to Accelerate Value-Driven Health Care
Health Improvement Collaborative of Greater Cincinnati achieves Aligning Forces for Quality status and forms Health Bridge, an electronic Health Information Exchange

1973	1974	1985
Managed Care Act established: stimulates growth of HMOs to reduce costs and promote prevention	National Business Group on Health forms to contain healthcare costs	Brent James, MD of Intermountain Healthcare develops national training center
1991	1993	1994
Institute for Healthcare Improvement forms	Institute for Clinical Systems Improvement founded in Minneapolis	<p><i>Boston Globe</i> healthcare columnist, Betsey Lehman, dies at Dana Farber Cancer Institute from massive chemotherapy overdose; two weeks later, Lucian Leape, MD publishes <i>Error in Medicine</i></p> <p>Ken Kizer, MD, named head of U.S. Department of Veterans Affairs and oversees quality transformation</p> <p>Centers for Medicare & Medicaid Services publishes report on National Health Expenditures, raising more alarm about escalating costs</p>
2000-2003		2004
<p>Harvard Business School publishes Beth Israel-Deaconess case study about Toyota industrial engineering processes in a hospital</p> <p>CDC and Agency for Healthcare Research and Quality fund major infection reduction demonstrations in Pittsburgh with PRHI; region reduces central line infections by 68%</p> <p>Robert Wood Johnson Foundation funds new regional quality coalitions and quality improvement demonstrations, and later a RAND study on regional quality collaboratives</p> <p>Rewarding Results: Aligning Payments with High-Quality Health Care funded by Robert Wood Johnson Foundation and the California HealthCare Foundation to test the use of financial incentives to improve the quality of health care</p>	<p>RAND study, <i>Quality of Care Delivered to Adults in the United States</i>, by McGlynn et al, highlights inadequacy of best practices in primary and preventive care</p> <p>Rosemary Gibson publishes <i>WALL OF SILENCE: The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans</i></p> <p>Two publications, <i>Complications</i>, by Atul Gawande, MD, and <i>Escape Fire</i>, by Don Berwick, MD, ignite interest in safety and quality concerns</p> <p>Oregon Health Care Quality Corporation, Healthy Memphis Common Table, Kansas City Quality Improvement Consortium, California Quality Collaborative, P2 Collaborative of Western New York and Quality Counts (Maine) are founded</p>	<p>Porter and Teisberg publish <i>Redefining Competition in Health Care</i> in Harvard Business Review, advocating value-based competition in health care</p> <p>Robert Wachter, MD, publishes <i>Internal Bleeding: The Truth Behind America's Epidemic of Medical Mistakes</i></p> <p>Wisconsin Collaborative for Healthcare Quality, Iowa Healthcare Collaborative and Puget Sound Health Alliance are founded</p>
2008	2009	2010
<p>U.S. Department of Health and Human Services Secretary Michael Leavitt establishes a national coalition of regional health improvement collaboratives by officially designating a number of Chartered Value Exchanges (CVE) housed at the Agency for Healthcare Research and Quality</p> <p>The Network for Regional Healthcare Improvement held its second Payment Reform Summit</p>	<p>Jewish Healthcare Foundation establishes Center for Healthcare Quality and Payment Reform; Harold Miller circulates seminal article on payment reform, <i>From Volume to Value</i></p> <p>Reuters study estimates that the U.S. healthcare system wastes between \$505-\$850 billion per year</p>	<p>Patient Protection and Affordable Care Act (PPACA) passes</p> <p>Milliman study finds that medical errors cost the U.S. economy \$19.5 billion per year</p> <p>Regional Health Improvement Collaboratives play prominent roles in the Office of the National Coordinator of Health Information Technology Regional Extension Center and Beacon Community Cooperative Agreement Programs</p>

REGIONAL HEALTH IMPROVEMENT COLLABORATIVES: THE FOUNDATION FOR SUCCESSFUL HEALTHCARE REFORM

By Harold D. Miller, President and CEO, Network for Regional Healthcare Improvement

The Need for Regional Health Improvement Collaboratives

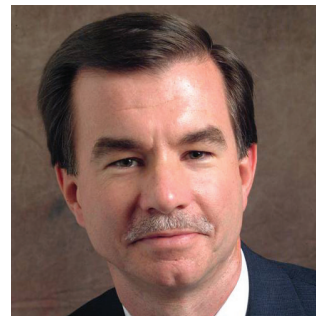
One of the greatest challenges facing the nation is how to make the American healthcare system more affordable while maintaining and improving its quality. Although many people believe costs cannot be reduced without rationing care, the evidence is clear that healthcare costs can be significantly reduced while improving quality, such as through prevention of illnesses; avoiding unnecessary and potentially harmful tests, interventions, and medications; eliminating harmful and expensive infections and medication errors; and educating patients with chronic disease about how to manage their conditions and prevent the need for costly hospitalizations.

However, there are also many barriers that have prevented these opportunities for reducing costs and improving quality from being realized.

For example:

- Patients (and healthcare providers who are trying to advise them) cannot get the data on quality and costs they need to choose the highest-quality, highest-value providers and services;
- Doctors, nurses, and other healthcare professionals typically do not have the kind of training or experience needed to redesign care processes in order to improve quality and reduce costs;
- Health plans and government programs fail to pay for many high-value services and often financially penalize physicians, hospitals, and other healthcare providers for reducing infections, errors, complications, and unnecessary services;
- The fragmented structure of healthcare providers and the lack of efficient methods of sharing information among them makes it difficult to coordinate care for patients; and
- Health plan benefits are often not structured in ways that enable and encourage consumers to improve their health, adhere to treatment plans, etc.

Clearly, if healthcare reform efforts are to succeed, multi-faceted approaches will be needed to overcome all of these barriers in a coordinated way. These approaches will, by necessity, be different in different parts of the country; the significant differences across the country in the structure of health care and in the specific types of cost and quality problems in each community make it unlikely that any one-size-fits-all national solution will work.



Harold D. Miller

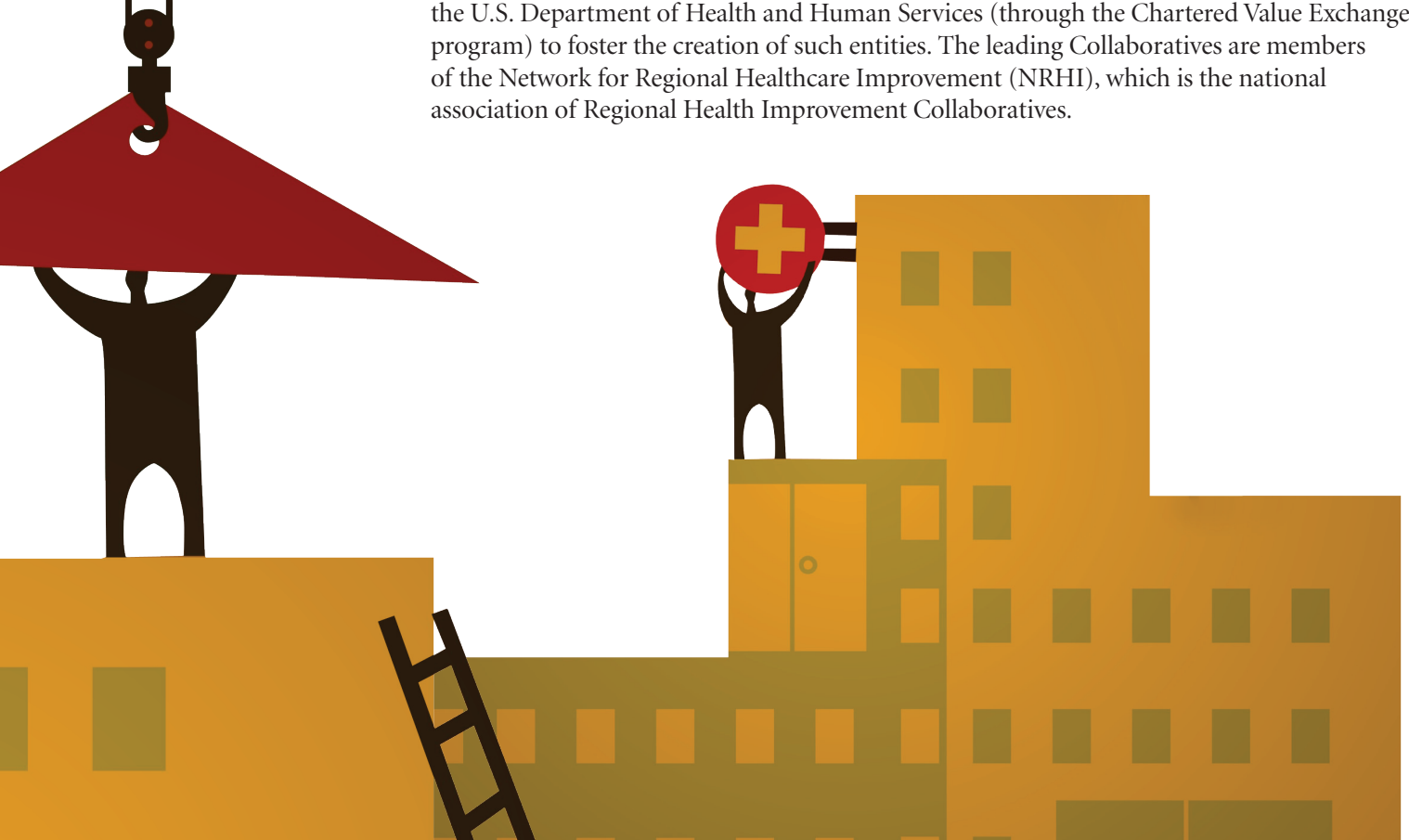
Moreover, since all of the healthcare stakeholders in a community – consumers, physicians, hospitals, health plans, businesses, government, etc. – will be affected in significant ways, they all need to be involved in planning and implementing changes. In many communities there is considerable distrust between different stakeholder groups, so a neutral facilitator will likely be needed to help design “win-win” solutions.

A growing number of communities are recognizing that Regional Health Improvement Collaboratives (RHIC) are an ideal mechanism for developing coordinated, multi-stakeholder solutions to their healthcare cost and quality problems. A RHIC does not deliver healthcare services directly or pay for such services; rather, it provides a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system.

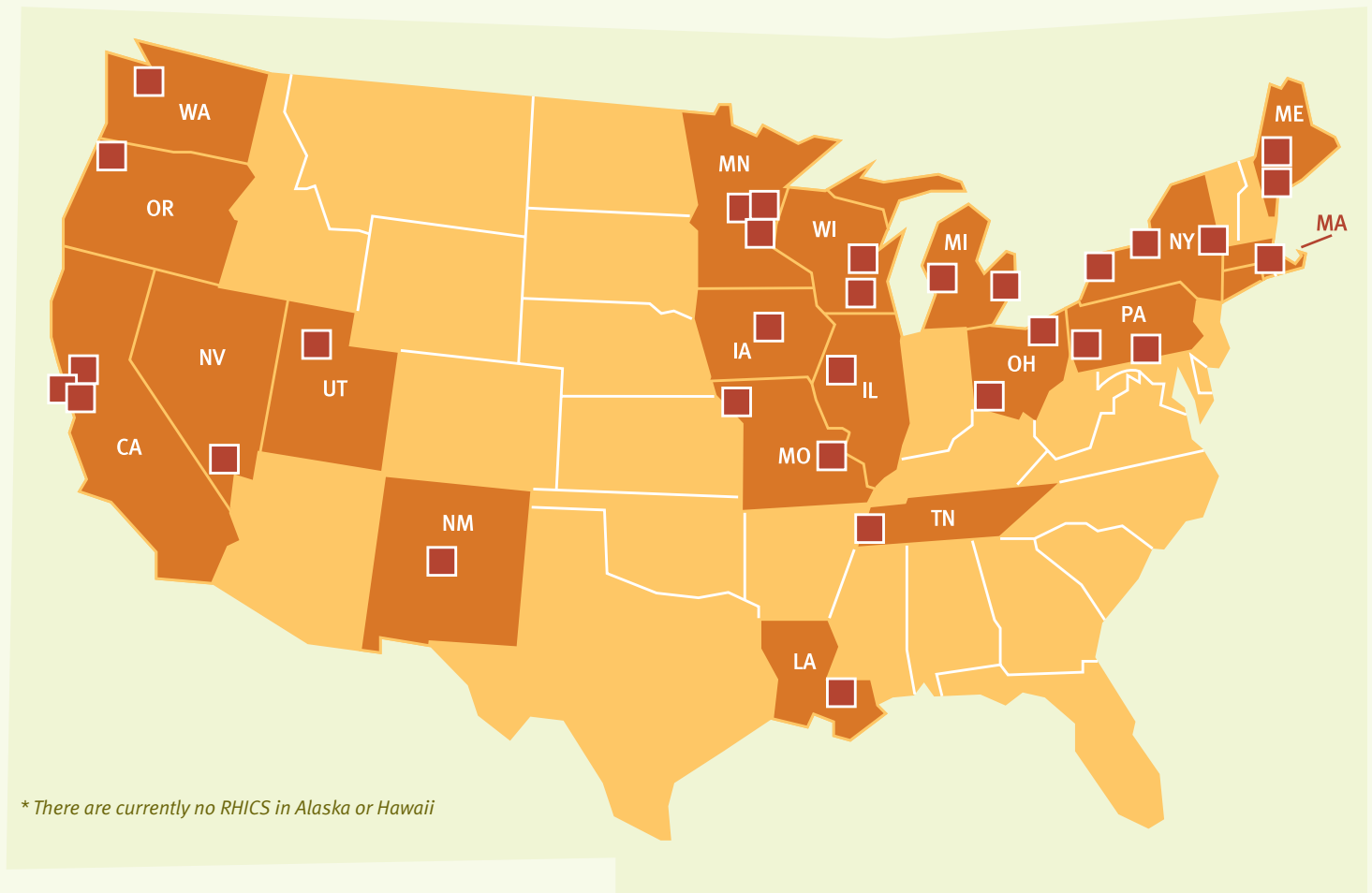
Regional Health Improvement Collaboratives have three key characteristics:

- They are non-profit organizations based in a specific geographic region of the country (i.e., a metropolitan region or state);
- They are governed by a multi-stakeholder board composed of healthcare providers (both physicians and hospitals), payers (health insurance plans and government health coverage programs), purchasers of health care (employers, unions, retirement funds, and government), and consumers; and
- They help the stakeholders in their community identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities.

In 2010, there were more than 40 Regional Health Improvement Collaboratives in the country. Many were formed relatively recently, but some have been in existence for 10 - 15 years, or longer. There has been a dramatic growth in the number of Regional Health Improvement Collaboratives in recent years, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts by the Robert Wood Johnson Foundation (through the Aligning Forces for Quality program) and the U.S. Department of Health and Human Services (through the Chartered Value Exchange program) to foster the creation of such entities. The leading Collaboratives are members of the Network for Regional Healthcare Improvement (NRHI), which is the national association of Regional Health Improvement Collaboratives.



Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement



Albuquerque Coalition for Healthcare Quality

Aligning Forces for Quality – South Central PA

Alliance for Health (West Michigan)

Better Health Greater Cleveland

California Cooperative Healthcare Reporting Initiative

California Quality Collaborative

Finger Lakes Health Systems Agency

Greater Detroit Area Health Council

Health Improvement Collaborative of Greater Cincinnati

Healthy Memphis Common Table

Institute for Clinical Systems Improvement (Minnesota)

Integrated Healthcare Association (California)

Iowa Healthcare Collaborative

Kansas City Quality Improvement Consortium

Louisiana Health Care Quality Forum

Maine Health Management Coalition

Massachusetts Health Quality Partners

Midwest Health Initiative (St. Louis)

Minnesota Community Measurement

Minnesota Healthcare Value Exchange

*Nevada Partnership for Value-Driven
Health Care (HealthInsight)*

New York Quality Alliance

Oregon Health Care Quality Corporation

P2 Collaborative of Western New York

Pittsburgh Regional Health Initiative

Puget Sound Health Alliance

Quality Counts (Maine)

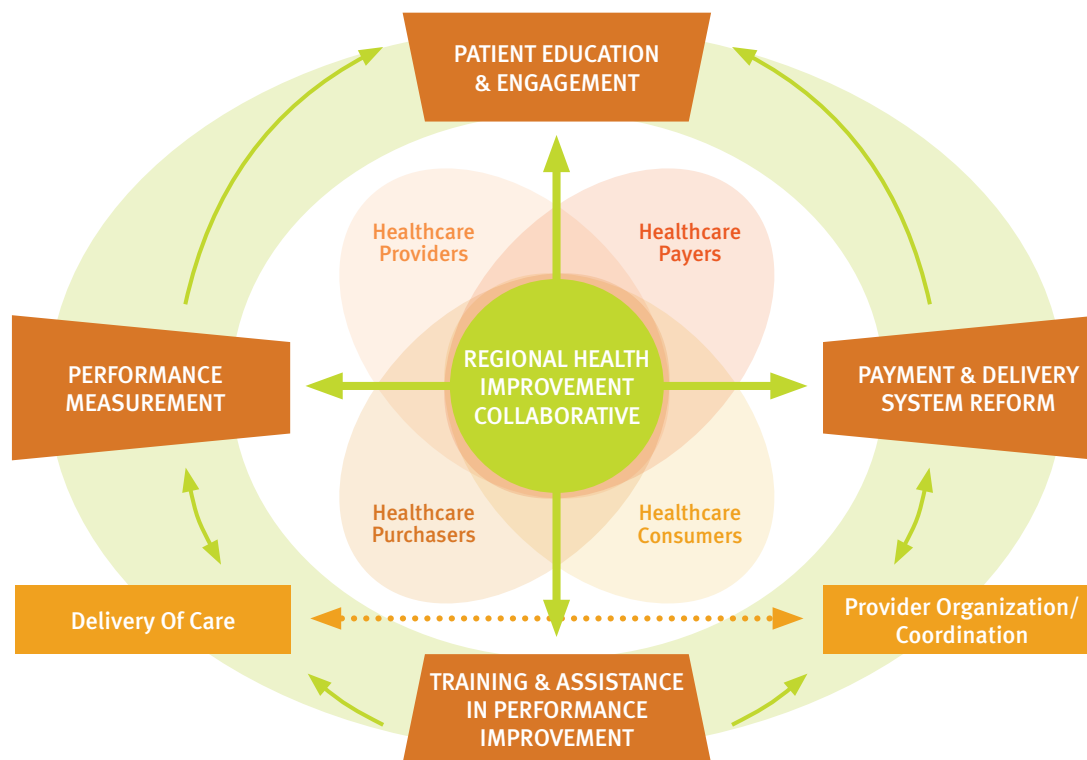
Quality Quest for Health of Illinois

*Utah Partnership for Value-Driven
Health Care (HealthInsight)*

Wisconsin Collaborative for Healthcare Quality

Wisconsin Healthcare Value Exchange

The Roles of Regional Health Improvement Collaboratives



The Roles Regional Health Improvement Collaboratives Play

Regional Health Improvement Collaboratives help their communities to deliver higher-quality, more affordable health care in many different ways. Five of the most important roles they are playing across the country are measuring health system performance, facilitating payment and delivery system reform, providing training and assistance to providers, educating consumers, and helping to plan and coordinate the many different health improvement activities in the community.

1. PERFORMANCE MEASUREMENT

It is a well-known principle that “you can’t manage what you can’t measure.” In the case of healthcare reform, communities need the ability to identify opportunities for reducing costs and improving quality and to monitor whether those opportunities are being successfully addressed. Regional Health Improvement Collaboratives can serve as neutral, trusted sources of actionable information about the cost and quality of healthcare services, the health of the population, and/or the extent to which state-of-the-art methods of delivery, payment, and health promotion are being used in their communities.

Regional Health Improvement Collaboratives across the country are publishing reports on many aspects of the quality and cost of care that are not available to either the public or healthcare providers through any other source. These measurement and reporting initiatives are developed and operated with the active involvement and supervision of the physicians

and hospitals whose performance is being measured, so those providers can ensure that the measures are meaningful, and the data are accurate. This, in turn, increases the willingness of healthcare providers to change care processes in order to improve their performance.

Quality of Physician Services

Most Regional Health Improvement Collaboratives collect and publicly report data on the quality of care delivered by physician practices. The types of measures reported include both clinical processes of care (e.g., did all diabetic patients receive a test to measure their level of blood sugar?) and care outcomes (e.g., how many diabetic patients had well-controlled blood sugar levels?). Most of these measurement systems rely on health plan claims data, but the Wisconsin Collaborative for Healthcare Quality has pioneered a methodology to obtain clinical data directly from physicians to enable more comprehensive quality measurement. This system does not depend on physicians having electronic health record systems, thereby enabling broad-based participation. Similar approaches are now being used by other Regional Health Improvement Collaboratives, such as Minnesota Community Measurement and the Health Improvement Collaborative of Greater Cincinnati.

While Regional Health Improvement Collaboratives typically use nationally-endorsed measures where they exist, they have also pioneered the development of new and improved measures where needed. For example, Quality Quest for Health in Illinois uses a multi-factor composite measure to determine the quality of colonoscopies, and it is currently pilot-testing a composite measure of whether all appropriate preventive care has been performed. The California Cooperative Healthcare Reporting Initiative conducts a telephone survey of primary care physician offices to assess after-hours physician availability and access to appropriate emergency and urgent care information.

Quality of Hospital Services

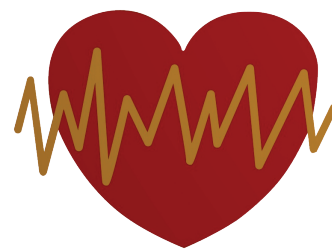
A number of Regional Health Improvement Collaboratives also report on the quality of care delivered in the hospitals in their community. Here again, the measures range from processes (e.g., how quickly heart attack patients were treated) to outcomes (e.g., infection rates and mortality rates). For example, the Iowa Healthcare Collaborative issues a detailed report with extensive measures of the quality and safety of patient care in hospitals in Iowa, and the Greater Detroit Area Health Council issues reports on a wide range of measures of the quality and safety of patient care in hospitals in southeastern Michigan. The Maine Health Management Coalition gives blue ribbons to hospitals with the highest performance on the quality of patient care.

Quality of Health Plans

Many Regional Health Improvement Collaboratives also report on the quality of care delivered to patients who have health insurance from a specific health plan. For example, the Puget Sound Health Alliance issues an extensive analysis of health plan quality and services, rating health plans on over three dozen different items.

Patient Experience of Care

In addition to clinical quality measures, a growing number of Regional Health Improvement Collaboratives are also collecting and reporting information on patients' experiences with healthcare services. For example, since 2005, Massachusetts Health Quality Partners has been collecting and reporting results from its statewide Patients' Experiences Survey on patients' experiences with their primary care providers, making Massachusetts the first state in the nation to report about patient care experiences publicly, down to the physician practice site level.



The Roles Regional Health Improvement Collaboratives Play

1. Performance Measurement
2. Payment and Delivery System Reform
3. Training and Assistance in Performance Improvement
4. Patient Education and Engagement
5. Strategic Planning and Coordination

Cost of Healthcare Services

Some Regional Health Improvement Collaboratives have also begun developing measures of the cost of healthcare services, such as the prices charged for individual services, the extent to which the most cost-effective services are used, and the total number of services used to address a particular healthcare issue. For example, Minnesota Community Measurement reports on the costs at different healthcare providers for procedures ranging from colonoscopies to labor and delivery. Quality Quest for Health of Illinois reports on the rate at which both primary care physicians and specialists prescribe generic drugs for their patients.

Disparities in Quality

In addition to reporting on the quality of care for all patients, some Regional Health Improvement Collaboratives are also reporting whether there are differences in the quality of care for different types of patients. For example, the Puget Sound Health Alliance compiles quality measures separately for patients with commercial insurance and patients whose health care is paid by the state Medicaid program and the Alliance highlights areas where there are significant differences. Better Health Greater Cleveland also separately compiles quality measures for patients who are uninsured.

It is important to recognize that not only are Regional Health Improvement Collaboratives collecting and publicly reporting an extensive array of quality measures, they are also actively using those measures to encourage improvements in the quality of health care in their communities. Indeed, in many cases, the measures have been developed specifically to support a local quality improvement initiative, rather than the other way around. For example, Minnesota Community Measurement is measuring the remission rate from depression as part of a major, successful community initiative to improve the treatment of individuals with depression.

2. PAYMENT AND DELIVERY SYSTEM REFORM

Although performance measurement efforts have made a positive impact on quality, only so much can be done when healthcare payment systems penalize improvement and the fragmentation of providers impedes coordination. Significant changes in the way health care is paid for, the way providers are organized, and the way consumer benefits are structured will be needed to achieve greater value in health care. To be successful, these changes must be made in a coordinated way. Regional Health Improvement Collaboratives can serve as a neutral planning and problem-solving forum where win-win multi-payer, multi-provider payment and delivery reforms can be designed.

In a number of cases, the performance measures collected and reported by Regional Health Improvement Collaboratives are being used by all employers and health plans in the community to reward providers that deliver higher-quality care and to encourage patients to use higher-quality providers. Using a common set of measures developed by the Regional Health Improvement Collaborative reduces administrative costs for both plans and providers. For example, the Integrated Healthcare Association in California assembles quality information to support the largest pay-for-performance (P4P) system in the country, involving 229 physician organizations and 35,000 physicians.

Regional Health Improvement Collaboratives were among the first healthcare leaders in the country to recognize that more fundamental payment reforms were needed than pay-for-performance systems. In 2007 and 2008, the Network for Regional Healthcare Improvement convened two national Payment Reform Summits that brought together national thought

leaders and regional stakeholders and made detailed recommendations on the types of reforms needed to payment systems and what was needed to implement these payment reforms successfully in regions across the country. Building on NRHI's national summits, a number of Regional Health Improvement Collaboratives have held regional Payment Reform Summits to build consensus in their communities on the types of payment reforms which should be implemented by all payers, so that physicians and other healthcare providers are not forced to deal with multiple, disparate new payment structures. For example, HealthInsight and its Nevada Partnership for Value-Driven Health Care held a statewide Payment Reform Summit in April, 2010 that brought together 140 individuals from across the state to develop recommendations for payment reforms to support medical homes for chronic disease patients and to support more efficient, successful care of major acute episodes.

Many Collaboratives are also working with all of the stakeholders in their communities to implement multi-payer payment reforms. For example, the Institute for Clinical Systems Improvement reached agreement among all of the major health plans in Minnesota on changes in payment to both primary care practices and specialists to support better care for patients with depression; this change has resulted in significant improvements in remission rates. The Puget Sound Health Alliance is co-sponsoring a demonstration project which will give participating primary care practices in Washington State both greater resources and greater accountability for helping patients avoid unnecessary emergency room visits and hospitalizations.

As more communities begin efforts to develop and implement payment changes, the need for the performance measurement capabilities of Regional Health Improvement Collaboratives described earlier will grow. For example, in order to define outcome targets and strategies for reaching them, healthcare providers will need information about the current costs and outcomes associated with their patients. The data that many Collaboratives are already collecting can serve as a trusted source of information that both providers and payers can use to design and implement new payment models.

Finally, no matter how much effort is put into designing new payment systems and delivery system reforms, implementation problems will inevitably arise. A Regional Health Improvement Collaborative that is supported by all stakeholders and perceived by them as neutral can provide a critical mediation mechanism for resolving problems quickly and effectively.

3. TRAINING AND ASSISTANCE IN PERFORMANCE IMPROVEMENT

Although measurement and reporting and changes in payment systems and organizational structures are necessary to support higher-value healthcare delivery, improvements in quality, efficiency, and patient satisfaction are actually achieved through the actions of frontline healthcare workers. Regional Health Improvement Collaboratives can operate programs which enable physicians, nurses, hospital administrators, and other healthcare professionals to obtain affordable training, coaching, and technical assistance on ways to analyze problems in care delivery and ways to design and successfully implement solutions.

For example, the Pittsburgh Regional Health Initiative (PRHI) pioneered the adaptation of Lean manufacturing tools from the Toyota Production System so that they could be successfully used to improve quality and reduce costs in health care. PRHI's "Perfecting Patient CareSM (PPC)" method has been used by hospitals, physicians, nursing homes, and





Value should always be defined around the customer.... Value depends on results... and is measured by outcomes achieved.... Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to outcomes achieved is dangerous... leading to false “savings” and potentially limiting effective care.

What Is Value in Health Care?
Michael E. Porter, PhD

The New England Journal
of Medicine; 363:2477-2481;
December 23, 2010



other providers all over the country to achieve dramatic reductions in hospital-acquired infections, preventable hospital readmissions, pre-term deliveries of babies, and many other areas that benefit patients and reduce healthcare costs.

The Institute for Clinical Systems Improvement in Minnesota has developed and maintains an extensive array of guidelines for healthcare services based on the best evidence available, and then it works to help healthcare providers implement the guidelines and make other improvements in their own organizations.

Regional Health Improvement Collaboratives can also help providers, either individually or in groups, to better organize and deliver health care in order to improve quality and efficiency. For example, several Collaboratives, including HealthInsight in Nevada and Utah, the Louisiana Health Care Quality Forum, and Quality Counts in Maine, are helping physician practices become patient-centered medical homes, implement electronic health records, and more effectively coordinate care with other providers.

4. PATIENT EDUCATION AND ENGAGEMENT

Even the best-performing healthcare providers can only do so much to improve quality and reduce costs without strong support and engagement from patients. Regional Health Improvement Collaboratives can help citizens in their communities (a) understand and actively engage in activities that will maintain and improve their health, (b) choose providers and services based on their cost and quality, and (c) support the delivery of higher quality, more coordinated care. For example, the Oregon Health Care Quality Corporation has developed patient-friendly materials to help people select quality healthcare providers and work with them to develop appropriate treatment plans. Minnesota Community Measurement has established “The D5: 5 Goals for Living with Diabetes” to make it easier for people with diabetes to manage their condition and to find the healthcare providers who can most effectively help them.

5. STRATEGIC PLANNING AND COORDINATION

Finally, in addition to the previous four roles, an increasingly important role for Regional Health Improvement Collaboratives will likely be to provide the critical planning, coordinating, and support roles that will ensure these many inter-related changes happen successfully and in a coordinated way. The structure of a Regional Health Improvement Collaborative is designed specifically to help build consensus among all healthcare stakeholders on the changes needed in their community, and then to provide support and coordinate the implementation of those changes.

The Structure of Regional Health Improvement Collaboratives

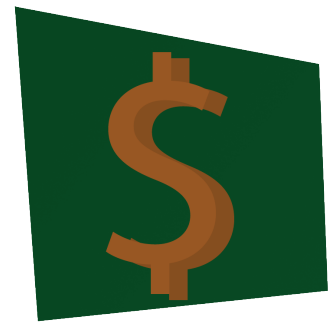
To be successful, the roles described earlier need to be performed with the full support and trust of all of the key stakeholders in health care:

- Healthcare providers, i.e., physicians, medical practices, hospitals, and health systems;
- Healthcare payers, i.e., health insurance plans and public programs such as Medicaid;
- Healthcare purchasers, i.e., employers who purchase health insurance for employees;
- Healthcare consumers and organizations representing consumer interests.

Regional Health Improvement Collaboratives ensure the support and trust of these stakeholders by actively engaging them in the governance of the Collaborative organization, as well as in the design and operation of individual programs. Indeed, a key difference between Regional Health Improvement Collaboratives and organizations such as Medicare Quality Improvement Organizations (QIOs), business health coalitions, regional health information exchanges, consumer health coalitions, medical societies, hospital associations, and others that work on quality improvement is that the Collaboratives are governed by individuals and organizations from all four of the key stakeholder groups. This is why Collaboratives are referred to as “multi-stakeholder” rather than merely “multi-member” organizations. Other differences between Regional Health Improvement Collaboratives and other organizations is that Collaboratives establish their direction through consensus among their members and implement their efforts through voluntary cooperation of the members, rather than through government mandates, financial rewards or penalties, etc.

Beyond this, however, no two Regional Health Improvement Collaboratives are structured exactly alike. Collaboratives are very diverse in terms of their goals, structure, and programs because of the differences in the number, structure, and capabilities of the purchasers, payers, providers, and other community organizations in their local regions.

- Some Regional Health Improvement Collaboratives had their origins in efforts among healthcare providers to work collaboratively to improve the quality of care they were delivering, and then they evolved over time to involve a broader array of stakeholders. For example, one of the first Regional Health Improvement Collaboratives, the Institute for Clinical Systems Improvement (ICSI) in Minnesota, was established in 1993 by two healthcare systems (Mayo Clinic and Park Nicollet Health Services) and an HMO (HealthPartners); today, the majority of the members of the Board of Directors are physicians or staff of medical groups, but there are also representatives of health plans and consumers on the Board.
- Other Regional Health Improvement Collaboratives were initially formed through the efforts of health plans or businesses in the community seeking ways to control increasing healthcare costs or to address concerns about healthcare quality in the community. For example, both the California Cooperative Healthcare Reporting Initiative and the California Quality Collaborative are multi-stakeholder Regional Health Improvement Collaboratives, but they were formed through the leadership of the Pacific Business Group of Health (PBGH), a major business health coalition based in California, and they continue to be housed at PBGH. In some cases, the Regional Health Improvement Collaborative also serves as the community’s health purchasing coalition. For example, both the Maine Health Management Coalition and the Puget Sound Health Alliance are multi-stakeholder collaboratives, but their policy requires that a majority of the members of their Boards of Directors be healthcare purchasers.
- Still other regional collaboratives were formed from the beginning as multi-stakeholder efforts. For example, the Pittsburgh Regional Health Initiative (PRHI) was formed in 1997 as a community organization with representation from a wide range of groups that were interested in advancing healthcare quality—hospitals and physicians, health insurance plans, major employers, consumers, academics, foundations, local government, and civic leaders.



...Value is emerging as a concept—perhaps the only concept—that all stakeholders in health care embrace. ...No one can oppose this goal.... The value framework thus offers a unifying orientation for provider organizations.... Making progress in the value framework [he calls this the bad news] requires real teamwork, which sometimes seems an unnatural act in health care. It means capturing data in different parts of the delivery system...and sharing accountability for performance.

Putting the Value Framework to Work
Thomas H. Lee, MD

The New England Journal of Medicine;
 363:2481-2483; December 23, 2010

Some regions have two or more Regional Health Improvement Collaboratives. In these communities, one of the organizations typically takes responsibility for collecting and reporting on various measures of healthcare quality and/or cost, while another carries out initiatives designed to help healthcare providers improve performance on those measures.

As a result of this diversity, communities which do not have a Regional Health Improvement Collaborative but want to form one have a variety of models from which to choose. Since a common element of all Collaboratives is their multi-stakeholder structure, the most important first step in establishing a Collaborative is for leaders from each stakeholder group to seek out leaders from other stakeholder groups and reach agreement that the interests of their communities would be served best by having all stakeholders working collaboratively toward improving healthcare quality and reducing costs.

Sustainability of Regional Health Improvement Collaboratives

All of the work done by Regional Health Improvement Collaboratives is challenging, but one of the most challenging tasks Collaboratives face is obtaining adequate funding to support their work.

Collaboratives typically obtain their funding from three types of sources:

- **Membership “Dues.”** Most Regional Health Improvement Collaboratives rely on annual financial contributions from the healthcare stakeholders in the community. Unlike dues payments made to many professional associations, however, these payments will usually be treated as tax-deductible contributions because of the charitable tax status of the Collaborative. These types of payments are critical because they provide flexible funding to cover the operating costs of the Collaborative (rather than being restricted to particular programs).
- **Grants.** In addition to membership dues, most Regional Health Improvement Collaboratives rely on grants from foundations and government agencies to support their programs. In some cases, Collaboratives may receive unrestricted operating grants from foundations which can be used to fund general operations, particularly in the early years of their existence, but more typically, foundation grants will be restricted to use for specific projects and time-limited activities.
- **Fees for Services.** Some Regional Health Improvement Collaboratives provide specific services to healthcare providers or others for which they charge a fee. For example, some Collaboratives provide consulting services or coaching to healthcare providers to help them improve their quality of care, or offer courses in quality improvement for the employees of healthcare providers.

Despite the key role that Regional Health Improvement Collaboratives can play in ensuring the success of federal healthcare reforms in local communities, there is currently no federal funding program that provides support for the administrative operations of Regional Health Improvement Collaboratives. Although the Department of Health and Human Services (HHS) and the Agency for Healthcare Research and Quality (AHRQ) promoted the creation of multi-stakeholder collaboratives through the Chartered Value Exchange (CVE) program, they do not provide any funding for general operating support of Regional Health Improvement Collaboratives. The Beacon Community Cooperative Agreement Program, which was established through the Office of the National Coordinator for Health Information Technology at HHS, has provided significant funding to a number of communities for multi-stakeholder healthcare improvement activities, but since the funding came through the 2009 American Recovery and Reinvestment Act, it is explicitly a time-limited program.

In the years ahead, it will be critical for Regional Health Improvement Collaboratives to have adequate resources both to maintain their current programs and to address the exponentially increasing demands that will be placed on them by healthcare reform efforts. Although program-specific funding is desirable, unrestricted funding is essential to support the core operations of the Collaborative and to provide the flexibility to pursue new opportunities in innovative ways. In addition, if Collaboratives are to remain truly multi-stakeholder, community-based organizations, those resources will need to come from all stakeholders in their communities, as well as from state and federal government sources.

Ensuring Successful Reform of America's Healthcare System

The federal Patient Protection and Affordable Care Act (PPACA) of 2010 will address one of the major barriers healthcare providers have faced in delivering high-quality, coordinated care: the lack of healthcare coverage for millions of Americans. It also provides the ability for the Medicare and Medicaid programs to pay providers in ways that support higher value instead of higher volume of care. However, because health care is actually delivered by physicians, hospitals, and other healthcare providers, not by the federal government, and because most patients will continue to have their healthcare services paid for by private health insurance, the nation's ability to achieve higher-quality, more affordable health care will still depend on the ability of individual communities to bring all of the stakeholders together to forge feasible solutions. In other words, the passage of the Patient Protection and Affordable Care Act means that Regional Health Improvement Collaboratives will be needed more than ever.

Although state governments will be playing an increasingly central role in healthcare reform in the future, partly as a result of the programs in the PPACA, they will not supplant the roles of Regional Health Improvement Collaboratives. While the regulatory powers and financial resources of state governments give them some unique strengths, such as the ability to mandate the submission of quality and cost data by providers and payers and the ability to provide anti-trust safe harbors to help establish multi-payer payment reforms and help independent providers coordinate their services, it is difficult for state governments to support multi-year healthcare transformation efforts through changes in state administrations and changes in fiscal priorities, and it is difficult for them to balance regulatory enforcement powers with programs to facilitate provider improvement. In contrast, the independence and stakeholder governance of Regional Health Improvement Collaboratives provides greater ability to support providers through multi-year transformation efforts and to do so in a way that can be adapted to the unique needs of individual geographic regions. Consequently, the greatest success in healthcare transformation will likely come from strong partnerships between state governments and Regional Health Improvement Collaboratives.

The greatest success in healthcare reform will be achieved if every community in the nation focuses on addressing the most important quality issues in that community, with support from both consumers and a broad range of healthcare providers, with participation by all payers, and with effective local mechanisms for monitoring implementation and resolving problems. Regional Health Improvement Collaboratives are an essential mechanism for accomplishing this, and consequently, supporting them should be a national priority.

GLOSSARY OF TERMS

Agency for Healthcare Research and Quality (AHRQ)

AHRQ operates within the U.S. Department of Health and Human Services with a mission to support research designed to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes, quality, cost, use, and access. The information helps healthcare decisionmakers—patients and clinicians, health system leaders, purchasers, and policymakers—make informed decisions and improve the quality of healthcare services. AHRQ was created by Congress in 1999 to expand on the work of the Agency for Health Care Policy and Research.

Aligning Forces for Quality (AF4Q)

AF4Q is an initiative of the Robert Wood Johnson Foundation that brings regional health improvement organizations together to set national standards and share information on successful models. AF4Q was launched in 2006 and provided community leadership teams with grants and substantial expert assistance to help them work with physicians to improve quality of care, to measure and publicly report on the quality of ambulatory care, and to engage consumers to make informed choices about their own health and health care. The program expanded in 2008 to include inpatient care, as well as a focus on reducing racial and ethnic gaps in care and enhancing the central role that nursing plays in good health care. There are currently 17 AF4Q communities.

Beacon Community Cooperative Agreement Program

The 2010 Beacon Community Cooperative Agreement Program awarded \$250 million in funding to 17 selected communities that have already made inroads in the multi-stakeholder development of secure, private, and accurate systems of electronic health record adoption and health information exchange. The Beacon Program allows these communities to build and strengthen their health information technology infrastructure and exchange capabilities to improve care coordination, increase the quality of care, and slow the growth of health care spending. Funding for the Beacon Community Cooperative Agreement Program is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act and is coordinated by U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology.

Chartered Value Exchange (CVE)

The CVE program was launched in 2008 by former Secretary of Health and Human Services, Michael Leavitt. CVEs receive practical resources to work collaboratively within specific regions to form value-driven healthcare markets through public reporting of healthcare cost and quality data, consumer education on healthcare quality, the development of quality improvement programs, and the exchange of learnings with other CVEs. There are currently 24 CVEs.

Network for Regional Healthcare Improvement (NRHI)

NRHI is the national membership association for Regional Health Improvement Collaboratives (RHICs). It was established in 2006 and currently has 31 members.

NRHI provides technical assistance, facilitates information sharing, and encourages national policies that support efforts by RHICs to improve healthcare quality and value by:

- Increasing the awareness of policy-makers and healthcare professionals about the key role that RHICs play;
- Providing technical assistance to RHICs in addressing specific challenges they face;
- Facilitating the ability of RHICs to share the practical knowledge they develop in order to help all collaboratives improve;
- Assisting additional communities to establish RHICs;
- Encouraging the development and implementation of healthcare payment systems, benefit designs, and regulatory structures at the federal, state, and local levels which support improved population health and higher-value healthcare delivery systems; and
- Advocating for national policies and programs that support the work of RHICs.

Regional Health Improvement Collaborative (RHIC)

The Network for Regional Healthcare Improvement defines Regional Health Improvement Collaboratives as:

- non-profit organizations based in a specific geographic region of the country (i.e., a metropolitan region or state);
- which are governed by a multi-stakeholder board composed of healthcare providers (both physicians and hospitals), payers (health insurance plans and government health coverage programs), purchasers of health care (employers, unions, retirement funds, and government), and consumers; and
- which help the stakeholders in their community identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities.

The major roles Regional Health Improvement Collaboratives play are:

- measuring health system performance;
- facilitating payment and delivery system reform,
- providing training and assistance to providers,
- educating and engaging consumers in health improvement, and
- helping to plan and coordinate the many different health improvement activities in the community.

COLLABORATIVES SPEAK FOR THEMSELVES

Every Regional Health Improvement Collaborative (RHIC) is a story about stakeholders coming together to try to solve the twin dilemmas of the U.S. healthcare system – high cost and unreliable performance. The search for solutions has led some Collaboratives to focus on improving population health and reducing disparities. Others have developed innovative approaches to disease management, payment reform, waste and inefficiency, and patient safety. As unique as each Collaborative is, their common goals and aspirations and their similar analyses of what ails U.S. health care and how to fix it, bind them in vital networks.





















































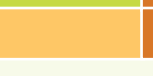

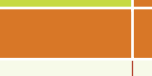

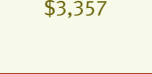

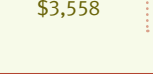
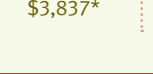
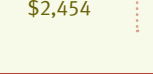
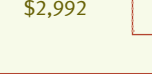

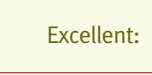

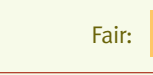

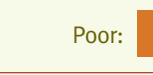


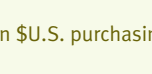
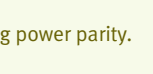
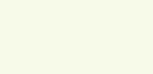
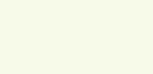
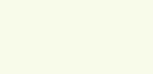
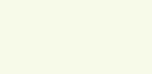
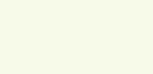
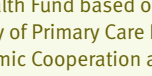
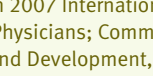
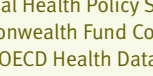
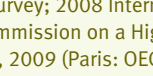
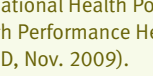
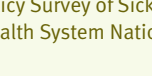
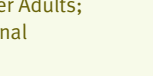
Several RHICs have a statewide focus. In Minnesota, for example, the Institute for Clinical Systems Improvement and Minnesota Community Measurement work together to advance statewide quality improvement. In other states, Collaboratives focus on health care in a specific city or region. A number of Collaboratives, such as the California Cooperative Healthcare Reporting Initiative and California Quality Collaborative, the Nevada and Utah Partnerships for Value-Driven Health Care, and the Pittsburgh Regional Health Initiative, are part of, or related to, a larger organization. They vary widely in size, with annual budgets mostly ranging from \$1 million - \$3 million, and staff sizes from 5 - 30. The figures may be confounded by the fact that some Collaboratives share staff and derive support from a parent organization. Current budgets may be inflated due to recent, but limited in duration, federal grants.

Many Collaboratives entered the scene in the decade between 1995 and 2005 in response to an awakening about the serious quality and safety concerns and spiraling costs of health care in the U.S.

Although healthcare costs have been rising in all developed nations, skyrocketing costs and variable quality in the U.S. surpasses all others by a wide margin. Apart from the public health issues illustrated by the graph on the following page, the rapid growth of healthcare costs has become an acute economic competitiveness problem in the U.S. Frustrated with the lack of national solutions to these problems, American employers and payers have sought regional ones.

Acknowledgements: To the leaders of the Collaboratives profiled in this edition of R&OT, thank you for contributing your time and expertise.

How does the U.S. measure up globally?

	Australia	Canada	Germany	Netherlands	New Zealand	United Kingdom	United States
OVERALL RANKING (2010)							
Quality Care							
Effective Care							
Safe Care							
Coordinated Care							
Patient-Centered Care							
Access							
Cost-Related Problem							
Timeliness of Care							
Efficiency							
Equity							
Long, Health, Productive Lives							
Health Expenditures /Capita, 2007	\$3,357	\$3,895	\$3,558	\$3,837*	\$2,454	\$2,992	\$7,290

COUNTRY RANKINGS

Excellent:



Fair:



Poor:



Note: * Estimate. Expenditures shown in \$U.S. purchasing power parity.

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

As data on the relatively poor performance and high cost of U.S. health care proliferated during the period 1994-2010, regional leaders recognized the urgency of reform. This led to the evolution and growth of the multi-stakeholder, regional collaborative. Some were created ad hoc. Others evolved from organizations that began with a different purpose, such as a trade association, a business group on health, or a Medicare Quality Improvement Organization. The Greater Detroit Area Health Council, Inc. and HealthInsight are examples of organizations with long histories that created RHICs.

On the following pages, we feature a selection of Collaboratives that displays the diversity of origins but similarity of purpose among RHICs. We hope that these brief descriptions of their history, leadership and current work reveal the transformative changes that they seek, the revolutionary nature of their missions to enhance value, their innovative methods and accomplishments, and the visionary people who have shaped them.¹

¹ Detailed information on these and other RHICs can be found at NRHI.org and on each organization's website.

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT



For 18 years, the Institute for Clinical Systems Improvement (ICSII) has served as a hub for using evidence-based medicine to deliver quality- and value-driven health care to patients in Minnesota and neighboring states. ICSII's demonstrated collaborative and innovative processes enable it to unite diverse stakeholders to address complex healthcare system issues that no single stakeholder can solve on its own.



John Sakowski
Chief Operating Officer

The Institute for Clinical Systems Integration, as ICSII was originally called, was established in 1993 by HealthPartners Health Plan, HealthPartners Medical Group, Mayo Clinic and Park Nicollet Health Services. ICSII was proposed by these founding organizations in a response to an RFP issued by the Business Health Care Action Group (BHCAG), a coalition of Minnesota employers, to administer a self-insured, tiered care-system network. ICSII was their innovative idea for improving quality across a diverse network of care delivery systems. A key feature of BHCAG's design was that only clinics that became members of ICSII could be included in the care-system network. BHCAG was directly involved in ICSII by having seats on the board of directors and having representatives on all committees and work groups.

John Sakowski, chief operating officer, was one of over 60 people assembled to develop ICSII's original business plan in 1992. Serving as Director of Clinic Systems for HealthPartners, he participated in a group charged with determining the feasibility of having a common automated medical record platform across a number of large systems in the Twin Cities. It became apparent that this was impractical, but there was still interest in seeing whether a common interface for providers could be created. In 1993, he led an ICSII-sponsored effort to design a model physician workstation. Shortly after completing this project, the chief administrative officer left ICSII and Sakowski, "jumped at the opportunity to work with Dr. Gordon Mosser, ICSII's founding president. I started in 1994 and it's been my honor to be here ever since."

ICSII's founding organizations had been working on their own programs to develop evidence-based clinical guidelines. They recognized that collaborating on this work would be more efficient, provide greater consistency, and offer greater potential to broadly impact the quality and value of care across the community. ICSII was open to any medical group that had a contract with HealthPartners, ICSII's sole health plan sponsor at the time. The prevalence of large group practices and the inclusion of providers in developing ICSII's clinical practice guidelines allowed it to quickly achieve a critical mass of providers.

These guidelines were written by physicians, nurses, and others from the member medical groups and hospitals. Each guideline included several measures of performance that the medical groups and hospitals could use in their quality improvement work. By 1994, health improvement groups from across the country were visiting ICSII to see firsthand how clinical practice guidelines that were developed based on scientific evidence were being adopted throughout the state.

ICSII developed 35 guidelines in its first three years and members were expected to implement all of them, supported by ICSII education on how to measure and report on the guidelines. But in the first few years, medical groups struggled to keep up with the demands of

implementing all of the guidelines; their efforts were a mile wide and an inch deep. In response, membership requirements changed. Instead of being expected to implement all guidelines, ICSI members chose several topics each year and made a commitment to put significant effort into improving results; they also made a commitment to share their results, methods and insights with other members. ICSI serves as a clearinghouse for disseminating what is learned throughout the Collaborative.

Clinical practice guidelines have become the basis for measurement of performance and public reporting of performance. Starting in 2002, many of the measures specified in the guidelines were adopted by a partner entity (Minnesota Community Measurement) for use in public reporting of medical group performance (not hospital performance, at least not at that time). Given that the measures had been chosen and defined by the medical groups, there were relatively few complaints about the measures. Thus a problem often encountered in other states was avoided, and public reporting of performance came about rather smoothly.

ICSI experienced major growth in 2001 when four additional health plans joined HealthPartners as ICSI sponsors. The addition of these health plan sponsors, which insure about 80% of Minnesotans combined, and the broadening of membership criteria to include hospitals and single specialty medical groups, made almost every medical group and hospital that serves Minnesotans eligible for membership in ICSI. By the end of the year, the number of member organizations almost doubled.

With statewide reach, ICSI tackled major health issues like diabetes across all member organizations. The significant increase in the control of diabetes over the past six years is at least in part due to the leadership of ICSI and its members in systematizing the delivery of evidence-based care. Through these activities, ICSI has become known as a “living laboratory” to conceive, develop, pilot and broadly implement quality improvement initiatives across the state. Besides conducting “action groups” providing members with assistance on clinical quality improvement topics through educational and collaborative activities, ICSI added action groups for improving access and addressing organizational needs, such as change management and building a culture that fosters quality. Patient safety also became an important part of the program, with action groups on topics such as reducing hospital-acquired infections and implementing rapid response teams.

Today, ICSI includes 60 medical group and hospital members representing 9,000 physicians. ICSI is sponsored by five Minnesota and Wisconsin health plans: BlueCross BlueShield of Minnesota, HealthPartners, Medica, UCare, and Security Health Plan of Wisconsin. ICSI’s program has evolved over the years in four phases: (1) the initial development of evidence-based guidelines, (2) expansion into support for clinical quality improvement, (3) development of multi-provider collaborations to improve care, and (4) provider-health plan joint initiatives to address overuse and underuse issues.

As ICSI became steadily more successful and more visible in the state (and nationally), various parties lobbied for ICSI to take on many other tasks: healthcare reform at the state level, payment reform, public reporting of performance, healthcare cost reduction, public health endeavors (direct to consumers), expansion of membership beyond Minnesota, development of healthcare information technology, health services research and others. As Dr. Mosser reflected, “it was continuously difficult to maintain constancy of purpose and avoid getting spread too thin.”



Gordon Mosser, MD, recently retired professor and general internal medicine physician, could be considered the “father” of the Regional Health Improvement Collaborative (RHIC) movement. He was the founding President of the Institute for Clinical Systems Improvement (ICSI) and shaped the vision of ICSI and influenced a national movement.

Dr. Mosser was the Associate Medical Director for Quality and Utilization at GroupHealth (now HealthPartners) when GroupHealth and its partners created ICSI. He served as ICSI’s president from its founding in 1993 until 2006. Dr. Mosser advanced quality in health care through the development of clinical guidelines and new collaborations among stakeholders – sharing data and implementing best practices. This approach ignited interest in quality improvement and provided a “way” for those with a will. Champions of healthcare reform in other regions took note and action. Dr. Mosser generated collaborations among these early leaders within the RHIC movement.

Dr. Mosser received a lifetime achievement award from the Minnesota Medical Association in recognition of his contributions toward improving the quality of health care and making Minnesota a leader in the quality improvement field.

In 2006, ICSI stakeholders identified the aspects of health care they most wanted to change—changes that would truly result in quantum leaps. They concluded that the greatest need for redesign exists in two areas:

- Shifting from systems of care that put healthcare providers and organizations at the center, to systems of care that are patient centered and focused on patient activation, safety, reliability, timeliness and equity of care;
- Shifting to a healthcare system that is value driven, with clearly defined quality, costs and service.

ICSI's reputation as a trusted, neutral convener has provided a foundation to engage a broad group of stakeholders on a number of redesign initiatives over the past four years. Its first redesign initiative was DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction), which brought care delivery systems, health plans, employers, consumers, and state government together to collaboratively develop new care practice and payment models to support primary care practices in providing evidence-based care for the treatment of adult patients diagnosed with depression. DIAMOND uses a team comprised of the primary care provider, a care manager, and a consulting psychiatrist to provide more frequent contact, education, motivation and coordinated care. Minnesota health plans pay participating clinics for this bundle of services.

The DIAMOND program is now offered through 73 primary care clinics. More than 6,500 patients have entered the program to date, and DIAMOND is getting five times the number of depressed patients into remission by six months as clinics that provide typical primary care.

Another major transformational initiative focused on an overuse issue—high-tech diagnostic imaging (HTDI). Minnesota, like the rest of the country, was seeing double-digit increases in MRI, CT, PET and nuclear cardiology scans—without a commensurate improvement in patient outcomes. ICSI facilitated a pilot in which 4,500 providers within five large integrated healthcare systems used an electronic decision support tool embedded in their electronic health record to ensure the appropriate ordering of HTDI scans. Among other successes, the five medical groups that have used this approach for three years have contributed to a 0% increase in HTDI claims from 2007-2010, improved clinic efficiencies, reduced patient exposure to unnecessary radiation, enabled provider-patient shared decision making, and saved \$84 million for the Minnesota health community.

Similar initiatives are now underway on palliative care, and ICSI plans to do significant further work on shared decision making and on preventable hospital readmissions.

In 2008, legislation designed to increase access, lower cost, and deliver more patient-centered care was enacted in Minnesota. ICSI was awarded contracts to assist with two programs authorized by the bill: the establishment of healthcare homes (more commonly known as medical homes) and the formulation of eight “baskets of care”—collections of healthcare services designed to treat particular health conditions or episodes of care. ICSI facilitated diverse stakeholder groups to develop the quality measures for these eight bundles, identifying barriers to their implementation, and recommending possible solutions to overcome those barriers.

ICSI's leaders view the Patient Protection and Affordable Care Act of 2010 as very much an extension of Minnesota's 2008 state healthcare reform legislation. In particular, ICSI is very interested in PPACA's establishment of regional resource centers for the development of decision aids, and the broad application of shared decision-making methods. Health care is local, and Regional Health Improvement Collaboratives like ICSI are the real world laboratories that can help assure that good policy gets put into practice and best practices become part of public policy.

MINNESOTA COMMUNITY MEASUREMENT

Minnesota Community Measurement (MNCM) is recognized as a national leader in using publicly reported performance measures to drive improvement in the quality and value of health care. MNCM started informally in 2000. Three medical directors from Minnesota's largest health plans recognized that each had measures of quality at a health plan level, but as separate plans they could not provide reliable measures to the medical groups striving to improve care. The three health plans were already working together, sponsoring the Institute for Clinical Systems Improvement's development of practice guidelines for medical groups. The medical directors recognized an opportunity to combine their data and jointly develop performance reports for physicians. For the first two years, the results were shared only with the medical groups and group names were removed. MNCM was officially incorporated in 2005 after other stakeholders, including the Minnesota Medical Association, the Minnesota Council of Health Plans, employers and consumers joined the effort.

MNCM began with a single diabetes care composite measure that reported on 54 primary care medical groups across the state. Since that time, MNCM has expanded to report on an additional 18 clinical care measures across primary and specialty care, as well as hospital care, patient experience, cost of care, and use of health information technology. MNCM now reports on data from over 960 clinics and medical groups, and over 140 hospitals. MNCM publishes results on its website and several local employers and health plans refer consumers to the website to assist them in making healthcare decisions. In addition, the Buyers Health Care Action Group, a local business coalition, has been instrumental in fostering alignment so health plans, large employers, and the state health programs use MNCM measures in their pay for performance and incentive programs.

MNCM's biggest success has been in engaging providers to use the measures to improve care. For example, the number of diabetics in Minnesota who are reaching levels of optimal care has more than tripled since reporting began in 2004. These improvements mean thousands more patients avoid the serious complications of the disease, including strokes, heart attacks, vision problems, and amputations. Minnesota medical groups have been using materials developed for the diabetes composite quality measure, called "The D5," to educate patients on important aspects of their care. Groups have also incorporated the measure into their electronic health records, developed automated reminders for patients and clinicians, placed the results on patient care fact sheets, and trained support staff to increase patient outreach.

MNCM has also developed several innovations that have helped increase the impact and scope of their measures. MNCM was one of the first organizations to collect medical record data directly from providers. This allows the use of outcomes measures on all patients including the uninsured, provides more timely results, increases provider use of the data, and allows the collection of data that can help identify and address disparities in care. MNCM has begun to help other regions with the tools and processes needed to collect quality measures from medical records.



James Chase
President

MNCM has demonstrated the importance of using patient functional status measures for care improvement. Patient functional status measures ask the patient about how they are feeling or how their condition has changed in order to evaluate the results of care. Functional status measures were successfully used in the DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) project, a collaboration between MNMCM and the Institute for Clinical Systems Improvement. MNMCM is also now implementing measures that will report, by provider, the quality of certain medical procedures developed in conjunction with a community-wide effort to reduce the impact of colon cancer in the state. While provider organizations and health plans will be implementing changes to improve care, MNMCM will be reporting measures of colon cancer screening rates, appropriate use of colonoscopy, and the quality of the colonoscopies performed. The community has established a goal of saving 500 lives by increasing early detection, using the measures to provide both motivation for improvement and to monitor progress.

Jim Chase, president, joined MNMCM in 2004 just before MNMCM released its first public report. He says, “I had experience working with providers, employers, and health plans across the state and saw this as an opportunity, building on what the health plans had started, to develop a multi-stakeholder collaborative that could have greater impact.” Chase has over 20 years of experience in the healthcare field and a strong commitment to improving the health of the people of Minnesota. Prior to his work at MNMCM, Chase spent nine years as Director of Healthcare Purchasing with the Minnesota Department of Human Services. He also held positions with Health Risk Management, Inc., UnitedHealthcare, and Fairview Hospitals.

From Chase’s perspective, “The biggest challenge has been keeping everyone working together collaboratively rather than competing. We have had to maintain focus on a few areas where we can have impact given limited resources, and at the same time meet the community’s demand to go further and faster to impact not just the quality of care, but also to improve value.” These challenges are not unique to MNMCM, but draw attention to the need to support the important work of Regional Health Improvement Collaboratives throughout the U.S.

With the community-wide commitment to transparency and care improvement, Minnesota stands ready to lead the changes that will be needed to implement the health system reforms anticipated in the Patient Protection and Affordable Care Act. Implicit in the bill is the recognition that the challenges to improving health care cannot be addressed simply by changing the price paid for each service. Our payment systems need to be redesigned; this will require the kinds of measures and reporting mechanisms that Regional Collaboratives, such as MNMCM, have created.

According to Chase, “The promise of healthcare reform is too important for our country to rely solely on efforts in Washington, DC to generate the needed changes. The experience in Minnesota has shown how effective measures can drive improvements in patient outcomes. They address areas where there is significant room for improvement, such as care redesign activities that achieve improved results, and align to provide consistent messages and comparable results. Most importantly, they need to be limited in number to achieve maximum impact.”

MASSACHUSETTS HEALTH QUALITY PARTNERS

Massachusetts Health Quality Partners (MHQP) was founded in 1995 by a group of healthcare, business, and community leaders as an informal alliance dedicated to promoting measurable improvements in the quality of healthcare services in Massachusetts. These pioneers believed that the development and reporting of comparable, evidence-based performance data would help drive quality improvement and lead to better patient outcomes.



Today, MHQP is nationally recognized for its breakthrough work in producing and reporting performance data on clinical quality and the patient experience. Many providers use MHQP data to plan and track the progress of their quality improvement initiatives, and MHQP's web-based reports give consumers tools for comparing hundreds of primary care practices and medical groups across the state.

The catalyst behind the formation of MHQP was a 1994 *Boston Globe* spotlight article that identified poor performing hospitals in the state, based on an analysis of mortality rates. As a result of the spotlight article and the subsequent defensive hospital response, the chair of the Massachusetts Hospital Association Board, the late Richard Nesson, MD, realized that hospitals and physicians will always be on the defensive if someone else is measuring their quality, and that was bad for building public confidence. He understood that hospitals and physicians should measure themselves and be accountable to the public for the results – he was an early advocate for transparency. “As is the case with many regional coalitions, MHQP was started with the visionary leadership of an individual,” says Barbra Rabson, executive director. MHQP's first public effort came with the 1998 release of a first-in-the-nation statewide report of patient experiences with Massachusetts hospitals. Three years later the leaders that made up the informal partnership of MHQP decided to incorporate as a formal non-profit entity to pursue foundation funding for its pioneering work.



Barbra Rabson
Executive Director

Rabson joined MHQP in 1998 when it was still an informal coalition. She brought experiences from the managed care, hospital, and healthcare arenas to her collaborative role at MHQP. “I took the job because I was attracted both to the mission and to the idea that organizations working together could achieve much more than any single organization could achieve on its own. 2010 marked my 12th year as the executive director of MHQP and it has been a great honor to have a role in nurturing MHQP into the trusted and nationally respected organization that it is today. It has also been very rewarding professionally to watch and encourage the proliferation of other regional collaboratives across the country.”

Important organizational milestones were the development of MHQP's Massachusetts Provider Database which maps the delivery of ambulatory care and provides the foundation for all MHQP projects, and MHQP's Physician Council, created when the organization began focusing on physician performance. The Physician Council brings physician organizations and leaders together under the MHQP umbrella to advise it on statewide performance measurement initiatives, collaborate on and establish quality priorities for statewide quality initiatives, and give physician organizations a formal voice in MHQP's strategic direction.

Rabson feels that “as health reform in Massachusetts continues to transform our healthcare system, it is vitally important to understand how patients are experiencing their care. How can we know if goals—high-quality and patient-centered care—are being met?” MHQP surveys consumers about aspects of the primary care experience that are fundamental to

high-quality care. The results of the patient experience survey are of special interest because the survey was conducted about two years into the implementation of Massachusetts health reform and allows comparisons with pre-reform data. On the positive side, the survey data largely dispel fears that adding hundreds of thousands of newly insured patients to primary care physician practices as a result of the Massachusetts reform law would adversely affect doctor-patient relationships. At the same time, there is a need for continued improvement in a number of aspects of patient care.

MHQP has been conducting this biennial Patient Experience Survey since 2005, when it was the only one of its kind in the nation. It is much more than a patient satisfaction survey. Patients assess their own experiences with multiple aspects of care, such as doctor-patient communication, including listening and giving clear instructions; timely access to care; knowledge of the patient's medical history, values and beliefs; and coordination between primary care doctors and specialists. Nearly 80,000 commercially insured Massachusetts residents responded to the most recent survey about their experiences with adult and pediatric primary care. Statewide, commercially insured patients' ratings of their experiences with primary care improved along several dimensions of the doctor-patient relationship or were similar to prior MHQP survey results.

With the 2009 survey cycle, MHQP began to see examples of practices across the state that used the reports to drive measureable improvement. Several practices that performed poorly on the prior survey in the areas of integration of care and health promotion implemented detailed improvement plans, leading to real improvement in performance. Although there continues to be a need for improvement, patients are now reporting significantly better physician knowledge of patients and there has also been some improvement in consistent integration of care between primary care and specialist physicians and more reliable follow up on lab results.

MHQP has addressed several notable challenges over the years. The first was building the trust of the community. MHQP established consensus policies for how MHQP data could be used, and maintained trust by assuring methodological rigor, attention to detail, and giving stakeholders a voice at the table. Their reputation nationally also helped build local acceptance. As they grew, keeping the coalition together by maintaining the commitment of a diverse group of stakeholders and making sure their concerns and issues were addressed was vital. Like many Collaboratives, generating ongoing financial support requires a balancing of diverse activities and funding sources. Throughout its growth, retaining an excellent and committed staff has been key to maintaining the organization's success.

The founding vision of MHQP was that information should be shared not only with the providers, but with the public. Despite this challenging philosophy, MHQP has successfully balanced the dual goals of providing trusted information to physicians to improve the care they provide to their patients, and providing this information to consumers to inform their healthcare decision making. Summarizing the challenges ahead, Rabson notes that, "The changes taking place in health care, in Massachusetts and nationally, are going to be complex and challenging for many years to come. If the doctor-patient relationship suffers as a result, the chances of success will be far more remote. By continuing to develop and report accurate, reliable, and trusted information on the patient experience, we can build an early warning system that will help keep us on track towards a more effective, efficient, and patient-centered healthcare system."

PITTSBURGH REGIONAL HEALTH INITIATIVE

The Pittsburgh Regional Health Initiative (PRHI) grew out of an effort in 1997 to position the Pittsburgh region competitively by achieving “best in class” status in a few select areas. Business leaders from the Allegheny Conference on Community Development aspired to create, in Pittsburgh, the highest value (best quality at lowest cost) health care in the U.S. The Jewish Healthcare Foundation (JHF) took the lead. What started as the “Working Together Consortium” was eventually incorporated under JHF as the Pittsburgh Regional Health Initiative.

Led by business and civic leaders, PRHI includes healthcare providers, insurers, purchasers, and a consumer health coalition. The Collaborative’s mission is to perfect clinical practices in health care. PRHI operates on the premise that quality assurance is the best cost containment strategy. PRHI was among the first regional collaboratives to focus on care improvement at the frontline, rallying clinical champions to use its Perfecting Patient CareSM (PPC) process improvement method to prove that delivering best practices without error or waste saves lives and money. The core concept is that value begins at the point of care.

Since its inception, PRHI has been headed by Karen Wolk Feinstein, PhD. PRHI co-founder, former Alcoa Chairman and U.S. Treasury Secretary Paul O’Neill, was instrumental in developing the founding vision of PRHI. He believed that the industrial engineering processes (such as Lean and the Toyota Production System) that helped to make Alcoa the safest organization in the world would work equally well to improve the quality and cost problems of healthcare delivery. O’Neill was an early thought leader in seeing the societal and business potential of value-driven health care. Feinstein had a unique role, serving both as President and CEO of the Jewish Healthcare Foundation and of its supporting organization, PRHI. As a student of social movements and revolutions, she recognized that O’Neill’s prescription would be as challenging as it could be transformational. Guided by a forward-thinking JHF board, PRHI set out on a “revolutionary” journey to perfect care in acute, long-term and ambulatory care settings.

To achieve its vision, PRHI developed its own quality improvement method called Perfecting Patient CareSM derived from Lean methodology. Recently, PPC on-site coaching and face-to-face educational sessions have been supplemented by a web-based quality improvement tool, Tomorrow’s HealthCare.TM To date, more than 3,000 healthcare professionals, including doctors, nurses, pharmacists, administrators, and technicians have received PPC training. While the majority of the participants have come from facilities in the Pittsburgh area, PPC teams have been recruited to do training in 26 states, 267 organizations, 137 hospitals and practices, and for nine insurers. PRHI has successfully demonstrated the power of PPC to deliver safer, more efficient, and proven care simultaneously. This track record has earned PPC national and international recognition as a catalyst for breakthrough improvements in every aspect of healthcare delivery: reducing hospital-acquired infections and patient falls; reducing hospital readmissions among patients with chronic diseases; and improving the quality of care in intensive care units, pathology labs, nursing homes, primary care practices and community health centers.

Recently, awareness has grown about the financial disincentives for safety, efficiency and best practices that are embedded in our healthcare payment systems; savings achieved with improved care do not accrue to the providers who deliver care or the employers who pay for care.



Karen Wolk Feinstein
President and CEO

In response, PRHI's parent organization, the Jewish Healthcare Foundation, created the Center for Healthcare Quality and Payment Reform to provide thought leadership in delivery and payment system redesign.

PRHI has been fortunate to have access to all-payer, hospital discharge data collected by the Pennsylvania Health Care Cost Containment Council, enabling PRHI researchers to perform unique and informative analyses that are being used to target quality improvement initiatives, and to help healthcare providers identify patients at high risk for avoidable readmissions. These studies informed the launch of PRHI's Chronic Disease Readmission Reduction Project, which enabled two community hospitals, each matched with an affiliated large PCP practice, to achieve significant reductions in readmissions for patients with Chronic Obstructive Pulmonary Disease (COPD). This project demonstrated that it is possible to work across levels of care to improve patient outcomes that also generate savings.

PRHI's work to reduce COPD readmissions is directly relevant to its recent efforts to develop Accountable Care Organization (ACO) pilots. PRHI is now engaging two community hospitals and their affiliated primary care practices to form Accountable Care Networks around a coordinated readmission reduction program. In addition to community hospitals, PRHI is unique in envisioning the role of safety net providers and long-term care facilities in the ACO space. Also on PRHI's current agenda:

- Helping community health centers, the core of the U.S. health safety net, attain status as patient-centered medical homes, with support from the Commonwealth Fund.
- Assisting nearly 1,000 local primary care physicians as they implement electronic health records, as the Community Partner for the Centers for Medicare and Medicaid Services Electronic Health Records (EHR) Demonstration in western Pennsylvania to achieve quality improvements leading to meaningful use.
- Serving as subcontractor for the federal Regional Extension and Assistance Center for Health Information Technology for western Pennsylvania (PA REACH West).
- Partnering with their region's largest insurer to train hundreds of physician practices to transform their operations by adopting EHR technology.

Finally, PRHI is extremely proud to be participating in a first multi-regional health improvement collaborative partnership. PRHI, along with the Institute for Clinical Systems Improvement and the Wisconsin Collaborative for Healthcare Quality, received Agency for Healthcare Research and Quality funding for a joint project to integrate screening and brief intervention for depression, and unhealthy alcohol and/or drug use in the primary care setting. The AHRQ grant also provides for national dissemination of findings and materials through NRHI.

A major challenge is spreading breakthroughs in best clinical practice and safety. Feinstein notes that PRHI has created "Islands of Excellence" in units that adopt PPC methods. However, she regrets that improvements in one part of a facility are rarely applied elsewhere in the same institution. When a study by RAND suggested that the diffusion and sustainability of process improvement breakthroughs depends on the volume and intensity of training in any organization, PRHI sought to increase the reach of its training. In 2010, PRHI launched an online, web-based management, education, and improvement tool called Tomorrow's HealthCare.TM The objective is to transform whole organizations by teaching, supporting, recording, rewarding, and sustaining quality improvement.

Concludes Feinstein, "Organizational transformation is the gold standard. We are moving beyond repairs. Fortunately, we are working with two hospitals, one skilled nursing facility, a couple of FQHCs, and some entire departments that are well on their way to transformational behavior and culture change. Stay tuned!"

GREATER DETROIT AREA HEALTH COUNCIL, INC.

The Greater Detroit Area Health Council (GDAHC) is both a Chartered Value Exchange and an Aligning Forces for Quality community. This status supports its public reporting efforts that include an expanded consumer website with healthcare comparison tools –myCareCompare.org. Its success in engaging physicians enabled GDAHC to extend its efforts to improve quality with its measurement and public reporting work from hospital to outpatient settings. Achieving the participation rate of 80-90% of PCPs in the region who now report key metrics is a huge accomplishment.

As a result, GDAHC now publishes reports in three core areas:

- **Primary Care:** The Physician Organization (PO) Performance Report shows how well physicians in each PO provide care for their patients. Doctors also use this report to see how they compare to other doctors, to learn from each other, and to improve the care they give.
- **Consumer Engagement:** The Consumer Survey Report shows how consumers in Southeast Michigan rate the care they are receiving for chronic diseases like diabetes and asthma.
- **Hospital Care:** The Hospital Performance Report contains information about the quality of care provided by hospitals located in the seven counties of Southeast Michigan.

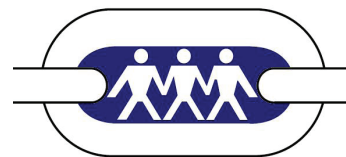
But GDAHC did not always have this focus. Its history is one of ongoing reinvention in response to the changing imperatives of healthcare delivery, particularly as the local economy experiences the enormous challenges associated with the transition of its industrial base away from automobile production to an economy with more diversified and smaller businesses.

GDAHC was founded in 1944 as the Detroit Hospital Council trade association. In the 1960s, it expanded to include payers and businesses, and through the 1980s was involved in regional health planning. After the state of Michigan took over its Certificate of Need program, group members continued to work on problematic health issues and developed the GDAHC. It expanded membership to all interested stakeholders and focused on reinventing the organization. Today, GDAHC members include health systems, providers, businesses, payers, and governmental and community agencies.

In the 1990s, GDAHC focused on public health issues and improving population health in addition to health system planning. The creation of GDAHC's Value Purchasing Initiative allowed self-funded, mid-sized businesses to pool purchasing on prescription, vision and dental coverage as a cost reduction method—a program that continues today and provides a revenue source for the Collaborative and an important resource for the region.

When Vernice Davis Anthony became GDAHC's President and CEO 10 years ago, the organization took the opportunity to rethink its role and what it could do for the region. Focused on cost, quality, and access, it launched the "Save Lives, Save Dollars" program to adopt standard performance metrics and measure performance, accelerate compliance with evidence-based guidelines, pay providers based on performance metrics, and foster organized systems of care. The program has demonstrated progress on diabetes, cancer screening, and antibiotic use for children with upper respiratory infections.

Greater Detroit Area



Health Council, INC.



Vernice Davis Anthony
President and CEO

Anthony has a passion for community work. She was attracted to GDAHC because of its focus on improving health status, reducing disparities and expanding access to care. She brings to the job a wealth of community health experience, coupled with public policy expertise, having served as Director of the Michigan Department of Public Health, as well as Senior Vice President for Urban and Community Health for a large health system. These positions were informed by her early career as a public health nurse where she learned the vital skills of how to help different kinds of people and organizations work towards a common goal. In her words, at GDAHC, “I get to do what I love the most and be able to generate, through a multi-stakeholder collaborative, major change in a region that has 4.5 million people.”

The main challenge has been keeping committed, engaged stakeholders at the table. With the economic downturn in the region and failures in the auto industry, GDAHC lost both big and small partners. Businesses are distracted and less engaged. Maintaining funding as the membership shrinks has been an issue and has stimulated GDAHC’s search for alternative funding sources to support operations. Meanwhile, the increase in the uninsured population added to the region’s challenges. “It’s a big stressor,” notes Anthony. “Access to care and the impact of disparities has always been important to us. The recession reinforces the need for us to continue to work on cost, quality, and access. We can’t increase access if we can’t lower costs.”

With the passing of the Patient Protection and Affordable Care Act (PPACA) in 2010, GDAHC, true to its mission, will engage in a strategic planning process over the next year to refine its vision and define new opportunities for healthcare improvement in the Detroit region afforded by the PPACA. In considering another reinvention, Anthony emphasizes that the PPACA “is a mandate to test new models and see what works, including payment reform” and feels confident that the GDAHC will again successfully draw on the kind of visionary leadership that has helped GDAHC continually reinvent itself to meet new challenges over the decades.

PACIFIC BUSINESS GROUP ON HEALTH

The mission of the Pacific Business Group on Health (PBGH) – a purchaser coalition – is to improve the quality and availability of health care while moderating cost. Since its founding in 1989, PBGH has been a leader in healthcare measurement, trend moderation, and system accountability through public reporting. Like other business groups on health, PBGH was founded to support the employers' viewpoint on health policy issues and to provide solutions for employers' healthcare-related problems, particularly the escalating costs of health coverage. Although PBGH is a purchaser coalition – and not a multi-stakeholder collaborative – it, uniquely, has two programs that may be characterized as Collaboratives and that work in tandem with PBGH on a value agenda. Both are coalitions of purchasers, health plans and healthcare providers. Both are staffed and managed by PBGH as part of its Quality Measurement and Improvement program.



California Cooperative Healthcare Reporting Initiative (CCHRI)

The first of these Collaboratives, the California Cooperative Healthcare Reporting Initiative, was established in 1993 by PBGH, along with several convening partners. CCHRI establishes and publishes common performance measures for health plans and medical groups and helps drive quality measurement and improvement in California. It offers a standardized process for collection and analysis for providers and health plans statewide, and acts as an independent and impartial third party to assemble and analyze the data. CCHRI benefits PBGH members and California consumers by assuring that plans can be compared on an “apples-to-apples” basis. Since the start of reporting in 1994, CCHRI survey results on health plans and physician groups have shown that there have been significant advances in patient care and satisfaction. CCHRI's major ongoing measurement projects include:

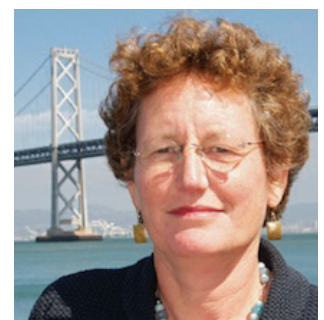
- Physician Group Patient Experience Survey used by the IHA Pay-for-Performance program
- Health Plan HEDIS Data Collection Project
- Consumer Assessment of Healthcare Providers and Systems
- California Physician Performance Initiative
- Physician-Level Patient Assessment Survey
- Provider After-Hours Access Survey

California Quality Collaborative (CQC)

The second program, the California Quality Collaborative, is a healthcare improvement initiative that focuses primarily on re-engineering care in the outpatient setting to improve the quality of performance. The mission of the CQC is to identify and accelerate the adoption of proven innovations in ambulatory care to achieve the highest attainable value. By promoting proven system changes and care redesign at physician practice sites, CQC aims to improve health care for over 13 million patients in the HMO and PPO populations. CQC is working on efforts to support and promote the redesign of health care to meet the Institute of Medicine's “Six Aims for Improvement” for health care that is: safe, effective, patient-centered, timely, efficient, and equitable.



David S. P. Hopkins
*Director of
Quality Measurement*



Diane Stewart
*Director
California Quality Collaborative*

CQC has met many of its goals, including:

- Improvements in all seven chronic care metrics among the 1.5 million people in the inland region of the state
- Boosted patient experience ratings for 6.5 million patients statewide
- A 15% reduction in ER visits in pilot sites in an 18-month period
- The engagement of 115 physician groups (providing care to 95% of non-Kaiser HMO enrollees in California) in care improvement activities

Diane Stewart, director of CQC, says of the synergy between the two programs, “It works—CCHRI measures and reports and CQC helps providers respond to those measures.” Stewart worked in healthcare operations on the outpatient side before joining PBGH and the CQC in 2001. Earlier in her career at the Harvard Community Health Plan, she saw firsthand the results of applying process improvement methods to health care. Her work at the Palo Alto Medical Foundation also drew on manufacturing methods for process improvement. Stewart’s appreciation of CCHRI’s statewide effort with providers and health plans on quality reporting, and her experience chairing the CCHRI Provider Committee, made the organization her top choice when she became interested in a different career path.

David S. P. Hopkins, PhD, is Director of Quality Measurement at PBGH and chairs the CCHRI Executive Committee. His background is in statistics and operations research, but he made the switch to healthcare administration in the early 1990s. While at Stanford University Medical Center, he went through the Advanced Training Program in Health Delivery Improvement at Intermountain Healthcare. “It changed my view of the world in relation to health care—I discovered how a quantitative person like me could help sort things out and make sense out of the data, then work with clinical teams to improve care.”

Hopkins takes pride in the evolution in CCHRI’s reporting and the impact it has had in the state. The health plan report card developed in the mid-1990s became richer and more useful over time. The original medical group survey is still in use and now supplies data for the largest P4P (nearly 200 physician groups) program in the country. He is excited by the potential of the California Physician Performance Initiative to perfect techniques to measure performance at the individual physician level for use by physicians, consumers, and health plans.

Another source of pride is the creation of the California Quality Collaborative as a result of the successful CCHRI Diabetes Quality Improvement Project, originally launched in 1997 to promote best practices in diabetes care. As the measurement set expanded, more providers came on board and more conditions were addressed. In 2004, CCHRI launched the Breakthroughs in Chronic Care Program to focus on a broader range of chronic conditions. In 2006, the program became independent of CCHRI and was renamed the California Quality Collaborative and expanded again to target improvements in a broad range of clinical conditions, patient service, and affordability within more than 110 physician groups and the 35,000 practices they support.

Both CCHRI and CQC have confronted challenges from those in the physician community who are not convinced that claims data can be accurately used to measure quality. David disagrees with this sentiment, however, asserting that, “Claims data can track key measures—like what tests have been done—basic, but also important tests like pap smears, mammography screenings, and HbA1c for diabetes. Since the measures are standardized and consistent across providers and years, they can be used for accountability and pay for performance.” And as Sophia Chang, MD, Director of Better Chronic Disease Care at PBGH’s partner, the California HealthCare Foundation noted, “CCHRI’s methodology is adapted to the unique challenges of the state.” CCHRI collects data for the entire state of California, which is larger than many countries. The achievement is all the more noteworthy given that California has tremendous regional variation within the state, a fractionated payer system, and little support from the state government for health improvement activities.

WISCONSIN COLLABORATIVE FOR HEALTHCARE QUALITY

The Wisconsin Collaborative for Healthcare Quality (WCHQ) traces its origins to the coincidental intersection of two separate yet related environmental forces. One was the publication of a controversial statewide hospital report. Based solely on claims data and published in 2001, the report ignited controversy. Provider groups complained that the metrics were neither useful nor balanced, and expressed interest in having a role in the development of measures that would actually help them improve their performance. About this same time, the leaders of several of Wisconsin's large physician groups began exploring the feasibility of collaborating on the development of a way of measuring performance at the delivery system — versus health plan — level. So, in early 2003, chief executives from healthcare provider organizations gathered to discuss forming a Collaborative. Recognizing the importance of performance measurement, these leaders joined together in partnership with healthcare purchasers to form the Wisconsin Collaborative for Healthcare Quality.

Today, WCHQ's Performance & Progress Report aligns its measures with the Institute of Medicine's "Six Aims for Improvement" to raise the quality of care. WCHQ has developed standardized data collection and analysis processes and tools for data submission. Its comparisons spur demonstrable quality improvement and greater efficiency among healthcare providers.

Chris Queram (now president and CEO of WCHQ) has been involved with the group from its start. At the time the Collaborative was forming, Queram was the CEO of a local business coalition called The Alliance. The Alliance's mission was to purchase health care on the basis of quality and value. Queram's organization was among the early groups to get involved with WCHQ. After WCHQ was formally launched, Queram served on the WCHQ board for two years representing the business coalition. As WCHQ grew and required a different type of leadership, he was invited to be CEO in 2005. "I was seduced by the vision, but also had a level of comfort having worked with them for several years during their creation and as a board member. I always recognized that transparency needed buy-in from physicians to gain traction and WCHQ had that." Queram had seen the organization's commitment to its approach and resulting success first hand.

WCHQ has both internal and external challenges. When Queram became CEO, the organization had a very strong work group structure, but building on the existing structure to realize WCHQ's ambitious mission took hard work. Developing a business model, building and sustaining infrastructure, and maintaining engagement of membership have been challenging. Queram feels that it is vital to keep businesses at the table, but their commitment varies with changes in leadership and pressure to show a return on investment for their involvement. Externally, working within the state has not been easy. There is some confusion between WCHQ and other organizations with overlapping missions. The state Medicaid program is strained and has not had the resources to invest in learning about WCHQ's distinctive approach, despite its potential to save money and improve quality.



Chris Queram
President and CEO

WCHQ's process involves physicians, data analysts, and quality specialists from the WCHQ membership who develop ambulatory care specifications that include all patients and all payers. Provider-sponsored health plans are prominent in Wisconsin. These plans are familiar with the pluses and minuses of HEDIS measures, particularly their inability to measure quality across payers. WCHQ's multi-payer focus has involved as many health systems as possible and engaged resources of most substantial health plans. Unlike many other healthcare reporting organizations, WCHQ does not rely only on administrative claims from commercial insurers to create their performance measures. Such claims-based reports exclude Medicare, Medicaid and self-pay patients, which typically account for nearly 50% of clinical practice. By uniting claims with clinical and patient data from multiple payers, WCHQ tracks each provider's entire practice. This comprehensive approach enables WCHQ to create a sophisticated measure set that evaluates both clinical processes and intermediate outcomes, like HbA1c, blood pressure and LDL control.

WCHQ has strong ties with the University of Wisconsin and is working with the faculty on innovative projects with the goal of moving beyond measuring to using the measures to motivate specific quality improvement actions. The projects include:

- An empirical evaluation of the impact of public reporting on clinical quality and patient experience measures
- Linkage of clinical health care, health status, and county-level health datasets to tell the "full story" of population health determinants and identify opportunities for improvement
- Translational research using WCHQ member organizations as a research network, and University of Wisconsin resources to assist with interventions focused on improving quality, reducing costs and organizational change management

Wisconsin has an unusually high rate of electronic health record (EHR) adoption which makes data collection easier. The city of Madison is home to Epic Systems Corporation, a large EHR vendor. Wisconsin also has a higher than average proportion of large, multi-specialty group practices which are more likely to invest in EHRs than small or solo practices. Queram feels that WCHQ's ability to improve the value of health care delivered in the state, coupled with the state's acceptance of EHRs (and soon health information exchange capabilities, another WCHQ initiative) can be an economic driver for Wisconsin.

HEALTHINSIGHT

Receiving a Beacon Community Cooperative Agreement Program award in 2010 marked the culmination of HealthInsight's 10-year journey to increase adoption of electronic health records (EHRs), and to advance health information exchange, public reporting, quality improvement and process redesign – efforts that have made HealthInsight a trusted community resource in Nevada and Utah.



HealthInsight was founded as a Professional Standards Review Organization (PSRO) in 1970 when the organization was tasked with improving the quality and efficiency of services delivered to Medicare beneficiaries. Most PSROs conducted “peer review” work to ensure that Medicare was paying for medically necessary care by reviewing patient charts to identify instances in which professional standards were not met. The PSRO program later was reinvented to become the current Medicare Quality Improvement Organization (QIO) program. In response to the Institute of Medicine's revolutionary recommendations, the QIO program's focus shifted to proactive community-based quality improvement and beneficiary education in the early 1990s. HealthInsight initially performed peer review work as an affiliate of the Utah Medical Association and then expanded into Nevada in the 1980s. HealthInsight's value-oriented work goes back to the mid-1990s. By that time, its formal affiliation with the medical society had ended and the organization's leaders developed a broader agenda.

Marc Bennett, president and CEO, has been with HealthInsight throughout its journey from QIO to an organization dedicated to increasing value in health care. He joined HealthInsight directly out of graduate school. At the time, he was simply happy to have a job. But he found his niche and has gone on to serve and guide the organization for over 20 years—half of it as the CEO.



Marc Bennett
President and CEO

Bennett's vision played a key role in the creation of HealthInsight's value agenda. One aspect of the QIO program focused on 10 hospital process measures. The goal was to reach 100% performance on those 10 measures no matter how long it took. Bennett felt that the level of effort required to get to 100% on those 10 measures would not yield the same results as would a more ambitious, multifaceted agenda. To advance this idea, HealthInsight identified major drivers of change that would have a bigger impact on the system. These included health information technology, payment reform, transparency, and consumer engagement.

Two organizational changes helped to solidify HealthInsight's new approach. First, in 1995, the board's composition shifted from a physician majority to a more representative mix of healthcare stakeholders – businesses, consumers, payers and providers. A few years later, leadership felt that local, engaged governance was needed to propel their value initiatives and so restructured the organization further. Today, HealthInsight is the management corporation supporting two separate organizations with parallel structures in Nevada and Utah – the Nevada Partnership for Value-Driven Health Care (HealthInsight Nevada) and the Utah Partnership for Value-Driven Health Care (HealthInsight Utah).

Prepared to tackle its new agenda with these organizational improvements in the early 2000s, HealthInsight set a goal of getting EHR adoption to a “tipping point” that could make a significant impact on care delivery. Early on, HealthInsight understood that the complexity of the modern healthcare system demanded that human memory be supported by technology to ensure patient safety. Fueled by the CMS Medicare Care Management Program pilot (Utah was one of four states receiving the award for FY 2006) which supported EHR utilization to manage chronic disease and preventive care, 60-65% of adult PCP services are now delivered by providers using EHRs. This effort has laid a foundation for future endeavors. The Nevada Partnership for Value-Driven Health Care and the Utah Partnership for Value-Driven Health Care were both designated as Chartered Value Exchanges in 2008. Moreover, in 2010 HealthInsight was awarded the Health Information Technology Regional Extension Center contracts for the Nevada and Utah regions.

Bennett is proud that HealthInsight’s reporting methods have drawn public attention to problems and accelerated change by motivating poor performing organizations to shift resources towards fixing problems. He is also pleased with the success in getting the Utah state legislature to sponsor multi-payer payment reform activities. It has been a challenge, however, to get multi-payer efforts going beyond talks. Bennett’s view is that changes will not be adopted across the system if every payer has a different payment system—there needs to be alignment of methods across payers or the providers will not make the needed changes in their work to allow them to focus on efficiency and quality, rather than on volume.

In looking forward, Bennett believes the key will be to look beyond “single lever” changes that are easily resisted or disregarded. In his words, “I believe that payment reform is the linchpin—that is, everything else feeds off of that and any effort to work on other kinds of quality components will be only marginally successful until we get payment reform to support and sustain those initiatives—this will be the big driver of change in the system.” The Beacon award supports HealthInsight’s full vision of a value agenda supported by payment reform as a sustainability strategy. Bennett hopes that the Beacon award will work to pull all the levers in the system and demonstrate lasting improvement.

OREGON HEALTH CARE QUALITY CORPORATION

Like several other regional collaboratives, the Oregon Health Care Quality Corporation (Quality Corp) originated from healthcare purchasers' concerns about the quality and cost of healthcare services for their employees and families. By 2000, the Oregon Coalition of Health Care Purchasers, made up of both private and public employers, had been working for several years with health plans to focus on quality improvement. These informal discussions led to support for an organization that could bring together multiple stakeholders to measure and report on primary care performance in Oregon.

A working group was formed to consider if the political, legal, and technical barriers to pooling health plan data and using that information to spur change could be overcome. "The answer was yes," according to Nancy Clarke, who represented the Oregon Public Health Department on the working group. A new non-profit emerged—the Oregon Health Care Quality Corporation—with a multi-stakeholder board of directors and a broad mission to collect, analyze, and leverage healthcare data for quality improvement, consumer information, and payment reform. Nancy Clarke later became one of the executive directors of the organization, overseeing a steady expansion of activities.

At the beginning, limited funding was the overriding issue. Early projects were supported by local foundations, business groups, and state health agencies, and included collaboration with Oregon's Medicare Quality Improvement Organization.

In 2007, Quality Corp made three big strides. First, the Robert Wood Johnson Foundation (RWJF) selected Quality Corp as one of its initial Aligning Forces for Quality (AF4Q) sites. Then, in response, eight Oregon health plans agreed to work together for healthcare system improvement and established a "venture capital" financing formula for Quality Corp. Finally, the Oregon Coalition of Health Care Purchasers committed to a new healthcare quality assessment tool ("eValu8"—created by the National Business Group on Health), and made supporting Quality Corp one of its top priorities.

Quality Corp's current major initiative, Partner for Quality Care, has evolved into a three-pronged approach to improving health care:

Quality Measurement and Reporting

Quality Corp brings stakeholders together to create a single source of data for assessing primary care quality at the clinic level across all payers using HEDIS measures, the most widely used quality measurement tool for ambulatory care. Quality Corp's current quality measures are in diabetes, cardiovascular disease, asthma, depression, women's health, and pediatric care. Data come from 10 health plans and include performance information for care provided by more than 75% of primary care practitioners in Oregon. To date, three rounds of quality measurement reports have been delivered to practitioners. Public reporting began in 2009 for clinics with four or more adult primary care practitioners.



Mylia Christensen
Executive Director

Quality Corp has also worked with the Oregon Office of Health Policy and Research, the Oregon Safety Net Advisory Council, the Oregon Office of Multicultural Health, and the Oregon Association of Hospitals and Health Systems to engage consumers, health plans, providers, and state agencies to develop a voluntary state standard for collecting race, ethnicity, and primary language data. In 2010, Quality Corp issued a report, “Creating a Voluntary Standard for Collecting Race and Ethnicity” and continues to work with state agencies and healthcare organizations to implement the voluntary standard.

Consumer Engagement

Quality Corp has developed a website for patients and consumers that provides tips on getting quality care, and allows them to compare the quality of care in hospitals and doctors’ offices in Oregon. In related work, Quality Corp and PeaceHealth Medical Group are recipients of an RWJF grant to implement a pilot program with five healthcare organizations that places patients at every level of decision-making in health systems. The initiative includes a statewide learning network, regional workshops, and a series of statewide reports on the status of patient and family engagement.

Quality Improvement

Partner for Quality Care offers quality improvement coaching to interested primary care providers at no charge. Two skilled quality consultants are available to help manage and review data, identify areas for clinical improvement, develop useful tools and interventions, and track results.

With funding from RWJF, Quality Corp and the Oregon Association of Hospitals and Health Systems have enlisted 15 hospitals in the Aligning Forces for Quality Hospital Quality Network. Hospitals are engaged in initiatives to reduce readmissions, improve emergency department efficiency and quality, and address language barriers.

According to Nancy Clarke (who recently stepped down and was succeeded by Mylia Christensen as Quality Corp’s executive director), “Winning physician support was our greatest challenge. We wanted this to be something we did with doctors rather than to doctors. With enormous outreach and real listening, we succeeded. We made a pledge to never have a meeting unless at least one doctor, one consumer, one plan and one purchaser were in the room at the same time. We’ve stuck to it; the dialogue is what matters.”

With this strategy as a constant, Quality Corp’s new Executive Director, Mylia Christensen, says she will be focusing on “developing a sustainable business model that builds on Quality Corp’s progress toward improving healthcare quality in Oregon.”

HEALTH IMPROVEMENT COLLABORATIVE OF GREATER CINCINNATI

The Health Improvement Collaborative of Greater Cincinnati (the *Collaborative*) was formed in 1992 as an incubator for innovation to create a healthier community. Initially focusing on direct service public health projects, the *Collaborative* has become a driving force for regional healthcare transformation.



In 2007, the *Collaborative* was tapped by the Robert Wood Johnson Foundation to pilot its ambitious Aligning Forces for Quality (AF4Q) initiative in Cincinnati. In further recognition of its central role in regional health systems improvement, the greater Cincinnati community was awarded a Beacon Community Cooperative Agreement Program grant. The independently operated subsidiary of the *Collaborative*, HealthBridge, was the lead grantee. In addition to being the linchpin in the community's Beacon Community program, HealthBridge is the nation's largest electronic health information exchange. Other partners include the Cincinnati Children's Hospital Medical Center, General Electric, the Greater Cincinnati Health Council, and the University of Cincinnati – all organizations with a history of working with the *Collaborative*. Then, when the Greater Cincinnati Health Council hospital association took the lead in securing a second round of AF4Q funding for the region, the partners were able to expand the initiative to address issues of inpatient quality and equity of care.

With support from a local health system for community-wide healthcare performance and public reporting, the *Collaborative* is nearing its goal of having quality metrics from 50% of PCPs in its region. Also at the cutting edge, in 2009 the *Collaborative* launched a patient-centered medical home pilot. The *Collaborative's* previous work on public reporting with payers, hospitals and affiliated physician groups laid the foundation for the development of the pilot. Significantly, the three major health plans in the region have agreed to pay practices an additional fee for case management.

The *Collaborative's* role as a trusted neutral convener of diverse community stakeholders was ideal for taking on these transformative functions. The hospitals were looking to build ties with other healthcare stakeholders in the Cincinnati region and began working with physicians, businesses and other community groups on moderately successful, small scale health improvement programs. The group received some early support from local businesses and foundations looking for public service projects, but the *Collaborative* was decidedly under-resourced in its early years.

With the arrival of Greg Ebel as Executive Director in 2006, the organization shifted its vision and developed a plan for growth in order to tackle major system-level change. Working towards redesigning a value-driven system, as opposed to pursuing incremental change, resonated with the *Collaborative* and its partners.



Gregory L. Ebel
Executive Director

It was helpful that Ebel understood the needs of local businesses in terms of health care. He had spent 30 years in corporate human resources before changing careers to fulfill a longtime interest in public service and policy. His positive experience working with leaders of one of the *Collaborative's* partner organizations, the Health Foundation of Greater Cincinnati, was another factor in his decision to accept the position. The *Collaborative's* new focus on increasing value across the healthcare system appealed to local stakeholders, including health plans and employers, spurring them under Ebel's leadership to become more engaged in working together on larger-scale initiatives.

Ebel attributes some of his organization's success to good timing, coinciding with the availability of funds (public and private) for efforts that matched the *Collaborative's* vision. Another key factor is a seemingly endless network of partnerships with a diverse group of large businesses, providers, non-profits, academia, and payers who share a vision and are open to leveraging each other's resources on joint projects that advance a healthcare value agenda.

Despite its success, keeping stakeholders engaged is a constant endeavor. The *Collaborative's* biggest challenge has been sustainability. "It's one thing to get people to sit at the table; it's quite another to get them to write a check. You must offer stakeholders products and services they value and will pay for, as the days of charitable contributions for the sake of a good cause are behind us. We are getting closer to that point but are not there yet," says Ebel. A more satisfying challenge is keeping up with the staffing and infrastructure needed to support the *Collaborative's* recent, tremendous growth. For the *Collaborative* and its partners, it has been a case of the bigger the vision, the greater the success.

HEALTHY MEMPHIS COMMON TABLE

Among Regional Health Improvement Collaboratives, Healthy Memphis Common Table (HMCT) is unique, evolving in 2003 out of a grassroots non-profit called Just Health Foundation which was formed to improve public health education and healthcare systems.

HMCT was the creation of national experts such as Bob Waller, MD, CEO Emeritus of Mayo Clinic, who called for a “common table” in Memphis to get people working together to solve health problems. Don Berwick, MD, along with other Institute for Healthcare Improvement leaders, helped focus the community on diabetes and obesity. Initially, founding members of HMCT, including representatives of various health improvement organizations, agencies, and passionate individuals, met around their own dining room tables to discuss ways to improve health in the Mid South.

HMCT’s first major event attracted more than 1,000 people to address childhood obesity and its impact on overall population health. Today, Healthy Memphis Common Table is a collaborative of over 200 organizations in Western Tennessee. Over 60 committees, or “common tables,” are convened to address such issues as childhood obesity, general health improvement, healthcare quality, public reporting, health equity, and payment reform.

Since 2003, HMCT has built a brand as a neutral and unique organization. The HMCT approach—to gather people around a common table and create conversations that generate regional change—takes advantage of the collective strength of the community to achieve the greater good. Participants address both population health reforms at a macro level and healthcare delivery system reforms at a micro level. There are numerous “tables” around which conversations are ongoing about issues of importance to the community with stakeholders leading the efforts. HMCT supports the agendas emerging from the “tables”—whether the stakeholders are business people, healthcare providers, religious leaders, or neighborhood groups. The requirement is that regular meetings are needed to sustain change. HMCT has evolved to focus on policy changes related to such public health issues as nutrition and smoking cessation, and is guided by the conviction that societal changes need to support individual behavior change—“We have to make the healthy choice the easy choice.”

Led by CEO Renee S. Frazier, HMCT’s priority focus is to bring more attention to transparency and public reporting in order to help consumers select physicians and make better healthcare decisions. Toward this end, HMCT conducted a patient survey on consumers’ experiences in physicians’ offices and published performance rankings of local physicians in a magazine format that reached 53,000 people. Frazier notes that, “in 2010 we were very successful in creating community public reports on hospitals, physicians, and medical offices for our website. The website has over 1,500 users who find it a trusted source of key healthcare information.”



Renee S. Frazier
Chief Executive Officer

Frazier moved to Memphis to join HMCT in 2009. She had been looking for something more community-based after working many years in corporate settings. Prior to joining HMCT, she served as the regional senior vice president and executive officer of VHA Pennsylvania, a division of the national hospital alliance, VHA Inc. She also served as a vice president of BlueCross BlueShield of Maryland and chief operating officer for Liberty Medical Center and Lutheran Health Care Corporation. Frazier had been one of the founding board members of the Pittsburgh Regional Health Initiative and was intimately familiar with Regional Health Improvement Collaboratives and the “value movement.” She considers her experience working in the health insurance and hospital industries, as well as early work with the Medicaid population and community health centers, as enabling her to “understand the perspectives of various stakeholders. HMCT is a perfect match with my cross-sectional experience, my commitment to transparency, and my passion for community-based efforts,” says Frazier.

HMCT’s primary concern has been finding sustainable sources of funding. Given the diversity of its “tables,” HMCT is not supported by one particular group of stakeholders and is not backed by a foundation. Because HMCT has an agenda beyond that of traditional business groups on health, employers have not been a source of ongoing revenue. Nevertheless, HMCT has been successful in receiving many grants, including The Merck Company Foundation, The Assisi Foundation of Memphis, Inc. and an AF4Q grant. Frazier is most proud of HMCT’s work in supporting community-driven neighborhood agendas. Working with local churches, HMCT was able to bring in \$2 million to the community to support a diabetes program around nutrition education, exercise and self management. In the summer of 2010, HMCT partnered with various community organizations to open a farmers market in a very low-income community in South Memphis that had been a “food desert” with no grocery stores within 15 miles.

“We are having the richest conversation around healthcare changes that I have ever experienced. Regional Health Improvement Collaboratives focus the conversation on issues that are important to their region and can respond quickly in a rapidly evolving environment.” Frazier feels that Congress is interested in hearing from the Collaboratives about what issues are important to their neighborhood and regional constituents, the dynamics of community relationships, and how Collaboratives can work in unique ways to address the issues.

Regional Health Improvement Collaboratives Featured In This Edition Of

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Health Improvement Collaborative of Greater Cincinnati

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HealthInsight (Utah and Nevada Partnerships for Value-Driven Health Care)

348 East 4500 South, Suite 300
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Healthy Memphis Common Table

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Institute for Clinical Systems Improvement

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Website: icsi.org

Massachusetts Health Quality Partners

42 Pleasant Street, Suite 3
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Minnesota Community Measurement

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Pacific Business Group on Health (California Cooperative Healthcare Reporting Initiative and California Quality Collaborative)

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