

In Support of Regional Healthcare Improvement
Recommendations for the National Quality Forum from Community Alliances

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Private sector coalitions created to promote the idea of efficient, affordable, quality healthcare have existed in the United States for decades. Whether led by the business sector, health-focused organizations, consumers or an amalgam of groups interested in better healthcare, the resulting community alliances emphasize local solutions and tangible outcomes. Connected and knowledgeable about local issues, such alliances are in a position to influence the change inherent in the current national mandate for healthcare reform.

The authors of this white paper asked 14 healthcare alliances involved in promoting performance measures, public reporting and other quality improvement tools to comment on where assistance and support from the National Quality Forum might enhance their success in the post-reform environment.

We also asked them to share examples of how they are bringing about positive change locally and identify market or other factors that obstruct their progress.

Our goal throughout was to provide a clear snapshot of the work a representative group of movement leaders is doing to promote healthcare quality locally and put their words into action. We looked for patterns in their observations that signified the primary issues local alliances are confronting. From these trends, we formulated high-level recommendations to guide NQF's strategic thinking about how it can have the biggest impact on helping advance local initiatives.

Beyond these key recommendations, the authors recognize there are individual comments in the sections describing "Barriers" and "Successes" that suggest other opportunities for NQF involvement. We spotlight several of these and invite the national organization to explore others in the narrative as avenues for collaborating with local groups based on available resources.

Characteristics of source alliances

Project collaborators selected candidates to interview from these six national networks:

- Aligning Forces for Quality
- Beacon Community
- Chartered Value Exchanges
- MONAHRQ
- National Business Coalition on Health
- Network for Regional Healthcare Improvement

Several sources share affiliation with more than one network.

The 14 sources (including one representing both a business coalition and regional quality alliance) characterize a deliberate mix of multi-stakeholder and single-member groups. The alliances, or collaboratives, do their work in markets that range from combined metro areas or multi-county regions to entire states. The survey sample is a balance of groups running well-established, sophisticated programs and newer alliances with gradually evolving programs. Individually, they addressed interview questions from the perspective of missions that focus on performance improvement, health literacy, database development and cost efficiency, among other primary objectives. All of them share a fundamental belief that unique regional efforts make a difference, that local alliances have an important role in shaping progress toward implementation of national performance standards and wider public reporting.

Eight of the community alliances surveyed for this report currently do some form of public reporting, five of them have plans to release reports in 2011 or in the near future. One alliance currently adheres to a policy of refraining from local reporting.

Appendix contains additional background information on each group.

NQF: Making the Connection

Most alliances contacted for this report say they view and value the National Quality Forum (NQF) primarily as a credible source for independent performance measures. Newer alliances in the survey group are less familiar with NQF and still learning how to tap the national organization as a resource. In all cases, recommendations for how NQF can do more to help community alliances succeed relate to barriers or challenges they encounter at the local level. The narrative that follows each of the high-level recommendations supports and sheds light on how the topic influences what is happening around the country.

***Recommendation:** Engage the leadership of national provider organizations, especially medical/specialty societies and boards, to generate support for local initiatives related to performance measurement, public reporting and quality improvement.*

A top issue for virtually every alliance interviewed is overcoming the resistance of providers, primarily physicians and hospitals, to adopting the comprehensive quality improvement initiatives they promote. Antagonistic providers and disengaged health plans limit the progress of local collaboratives, they say. Gail Amundson MD, President and CEO of Quality Quest for Health of Illinois, captures the frustration of many alliance executives. “It’s not the skill to do the work we lack, but the opportunity to move things forward.”

They recommend that NQF use its influence to disarm opposition among national physician and hospital member organizations to the use of performance measurement and public reporting. Where the associations lead, members often follow, say local collaborative executives. It affects the willingness of individual providers, groups or systems to cooperate fully with their alliance partners.

The Iowa Health Collaborative (IHC) concentrates on preparing providers to adopt quality improvement. A partnership of the Iowa Hospital Association and the Iowa Medical Society, IHC makes engaging these two important groups a central tenet of its work. “Change must come from the physicians so that’s where we start,” explains CEO Tom Evans, MD. Getting through to them, however, is the biggest challenge. Dr. Evans says an appeal at the national level to physicians’ belief in high professional standards would send a strong message that they cannot sit this one out.

Betsy Mulvey, Executive Director of the New York Quality Alliance (NYQA), recruits a group of physicians to help the alliance select acceptable measures. It gives alliance leaders a chance to hear physicians' views but also gain their acceptance of the process. She says encouraging the profession as a whole to become more involved in vetting measures and methods would reinforce her local efforts.

Chris Schultz, Vice President of the Indiana Health Information Exchange (IHIE) and John Kansky, Vice President for Business Development with the large, well-established data exchange, agree that getting physicians engaged in the process is a necessary challenge. They see physicians as similar to small business owners who need to hear a compelling business case before they commit to any program.

Since primary care physicians receive 70 percent of their revenue through Medicare and Medicaid, Ted Rooney of Quality Counts of Maine says the federal government has significant power over acceptance of measures among this group. Aligning Forces for Quality Project Director for his alliance, Rooney says NQF could help states do their part with a coherent and scalable "tool kit" or set of tactics to assist regional alliances in the implementation of the national quality strategy and a framework to guide voluntary efforts.

In Hawaii, Richard Chung, MD, Senior Vice President with the Hawaii Medical Services Association (HMSA), says the independent Blue Cross Blue Shield Association affiliate finds many physicians have reservations about the group's Pay for Performance (P4P) measurement process, seeing it as a move to reduce their fee schedule. And they raise questions about the accuracy of currently available claims data as undermining the validity of any reports. Dr. Chung adds that hospitals also guard their revenue and resist efforts to apply measures and supply data. "We must secure hospitals' commitment to healthcare delivery based on quality rather than quantity."

HealthCare21 in Knoxville, Tennessee, uses its influence with purchasers and suppliers who are members of the multi-stakeholder group to press for cooperation from providers. NQF can help their efforts, President and CEO Jerry Burgess says NQF can assist by helping change the American Hospital Association's stand against Leapfrog. Local collaboratives also need a

measurement tool for physicians, similar to Leapfrog, that gives them something robust and credible to “sell” to providers in their markets. Groups like HC21, he notes, are in a position to put what NQF creates into practice.

Shelley Hirschberg, Executive Director of the P2 Collaborative of Western New York, calls on NQF to identify physician leaders around the country with experience of performance

measurement and public reporting who will visit local alliances and

OPPORTUNITY: Establish affinity groups from various healthcare and business sectors that focus on sharing specific stories and testimonials with their peers.

address their peers. She suggests

that in-person testimonials from others in the profession who can speak knowledgeably about the practical value of proposed quality processes will do more than alliance leaders can to convince the serious doubters.

Recommendation: Assume an active role in overcoming the reluctance of national health plans to fully engage as a strategic partner in regional quality alliances.

Health plans offer another form of resistance. On one hand, plans with roots in the local market often count as active participants in broad-scale quality improvement efforts in the surveyed markets, whether as part of a collaborative’s core group or a later recruit. National health plans operating locally are not free to do so, according to alliances that commented for this report. Local affiliates of national plans follow corporate policies that generally stand against allowing them to participate in local quality efforts or sharing of data. Where those plans dominate the market—as in Maine and Illinois—they slow local efforts. Community alliance leaders ask NQF to explore strategies to reverse those policies and create an opening for local affiliates to support quality efforts in the markets they serve through data sharing and non-competitive reporting.

HMSA, based in Honolulu, represents this group as an independent affiliate of the Blue Cross Blue Shield Association (BCBSA). Although committed to transparency and consumer engagement, the organization does no public reporting. Rather, because they compete with another major health plan serving the market, they mirror a national BCBSA strategy of providing performance-related information only to members.

Dr. Chung of HMSA encourages NQF to include the health plan perspective in their work, especially when creating standards that allow information exchanges access to health plan data, including clinical data. “NQF should be an advocate and auditor of the process but involve health plans as equal not subordinate partners.”

Dr. Amundson of Quality Quest says most health plans in her state are national plans. Although alliance partners, they do not contribute data. She calls for a national effort to “get them in the game.” Raise awareness among consumers nationally about the importance of having accountable healthcare organizations, she says, and produce a *Consumer Reports*-style publication that spotlights national health plan comparisons—something local groups could use to advance their work.

Recommendation: Use position at national level to build bridges between quality networks that represent regional alliances and promote collaborative learning and sharing.

According to many local alliances responding to the survey, one of the best ways NQF can help them overcome a barrier or achieve momentum is to provide more opportunities to learn from one another. NQF’s focus on establishing national priorities and goals for performance improvement, ratifying national standards for measurement and public reporting, and working for wider implementation of these tools puts the organization in a position to know about high-profile successes around the country. There may be some initial resistance from the networks, but overcoming that resistance is a logical extension of the NQF’s emerging status as a convening entity. By working collaboratively with leaders of the recognized alliance networks, like NRHI and the national program office for the Aligning Forces for Quality program, NQF can collect information from the field, including results, and share it widely with all local collaboratives.

Among examples from the survey, Mulvey of NYQA expressed a wish to connect her Albany-based Chartered Value Exchange—a group she describes as emerging from startup status—with more mature CVEs or other alliances that can help them graduate to more sophisticated data gathering and reporting. With

resources tight, she says any chance to hear firsthand about strategies NYQA can adopt without reinventing is invaluable.

Executives at the Integrated Healthcare Association (IHA), a statewide multi-stakeholder alliance in California working with major health plans, physician groups, hospital systems and a range of constituents representing academic, consumer, purchaser and other interests, propose another way for alliances to learn from one another. Dolores Yanagihara, Director of IHA's P4P program, says national performance improvement goals give them good target levels for different endorsed measures. "But how do we know if we're there or not?" she asks. IHA would welcome a method of comparison, to see how the alliance measures against other similar communities in the country. It would give everyone a chance to learn what works and what does not in other places Yanagihara suggests. Such examples can help move local alliances toward quality and payment reform goals.

Quality Counts' Rooney seconds the idea of sharing good examples from groups around the country that are finding ways to improve the quality and delivery of care. He says the movement needs a national strategy to introduce best practices to a wider audience, but advises NQF to avoid curtailing the regional flavor of those approaches. Preserve the synergy that exists between regional efforts and credible national standards to promote acceptance of measurement methods and public reporting, he says.

Recommendation: Take bold steps to identify and promote adoption of a core set of high-leverage, high-impact performance measures within its existing portfolio while initiating aggressive action to fill critical measurement gaps.

NQF-endorsed measures are central to most initiatives the community alliances undertake in their markets. In describing how they apply or refine current measures against available

claims data sources, they note

OPPORTUNITY: Look at gaps in care for non-Medicare populations.

NQF must expand measures to

include a range of clinical areas and cost-of-care data, more specialty measures, and measures that focus on the health of consumers in their 20s and 30s.

As alliances gain growing access to forms of clinical information, which they consider essential to improving the validity of performance results, some groups are designing measures to match. But they look to NQF to guide development of credible standardized versions.

Like others that responded to the community alliances survey, the Puget Sound Health Alliance in Seattle looks for opportunities to add measures to their quality improvement efforts. A key focus for Puget Sound in 2011 is to introduce a cost-of-care measure. Susie Dade, Director of Performance Improvement for the alliance, says they do at times use homegrown measures, like four developed for generic prescribing, to augment national measures. She recommends NQF move quicker to produce endorsed tools that address these and other performance issues.

OPPORTUNITY: Streamline the performance measures consensus endorsement process.

Dade also calls on NQF to distill the list of national measures to a manageable number. “Having 600 measures on the list is no help,” she says. “Reduce it to a reasonable number that are evidence-based and apply directly to the quality agenda that is our focus.” She echoes comments from Louise Probst, Executive Director of the Business Health Coalition (BHC) and the Midwest Health Initiative (MHI) in St. Louis, who suggests creating more composite measures.

IHA’s Yanagihara says NQF could make it easier to work with the hundreds of NQF-endorsed measures if there was a way to locate them by specific criteria.

Susan McBride, who represents the F. Marie Hall Institute for Rural and Community Health at Texas Tech University Health Sciences Center (TTUHSC) that is working to expand the reach of health information exchanges in rural areas of west Texas, says her group needs more tools like MONARHQ devoted to clinical data and more open-source applications or standards to build bridges with existing data.

Several alliances modify national measures to meet local needs, a situation that IHIE explains poses a challenge for them when recruiting health plans to participate. VP for Business Development Kansky says they must invent an example when health plans ask to compare IHIE’s results from the modified measures to results using national standards. They look to NQF for help

analyzing the differences between local and national standards, determining how to align them, and evaluating best methods for integrating clinical and administrative data.

Recommendation: *Use the stature and imprimatur of the NQF to enhance recognition of and support for regional quality alliances by thought leaders and policymakers within Washington.*

Established alliances in particular highlighted the fact that local and regional groups are a valuable source of new ideas that NQF should mine. They cite as critical to achieving healthcare reform their knowledge of community challenges and opportunities, the ability to test bold concepts on a smaller stage and experience building diverse coalitions.

Christine Amy, Project Director of Aligning Forces for Quality South Central Pennsylvania (AF4Q SCPA), describes how active her organization is at reaching out to local partners for cooperation and other Aligning Forces colleagues for good ideas. She commends NQF for bringing a strong, needed focus to standardized measures, but says national leaders should acknowledge and tap into the pioneering efforts of local healthcare alliances. With the right resources, says Amy, groups like AF4Q SCPA can work quickly and effectively to build support for change.

Recognize and support the strength of what regional groups can do to gain wider acceptance of quality improvement strategies, says Dr. Amundson of Quality Quest. Like the trim on the rudder of an ocean liner, she suggests community alliances can position the national strategy to make the turn. “See locals for the solution we are.”

While NQF provides community alliances with strong leadership at the national level, Rooney of Quality Counts says it is easier for local collaboratives to get traction and affect change locally. “We’re important proving grounds,” he adds. “Working together, we could put this movement on steroids.”

Burgess of HC21 recommends NQF work with coalitions like his, groups that promote cooperation between employers, health plans, hospitals and providers.

“Physicians know us and know we are determined to get results because we also represent the buyers.”

Underscoring their willingness to collaborate with NQF on testing new tools, HC21 hopes NQF will help them develop a partnership in Tennessee that will roll out national physician measures and the P2 Collaborative is proposing themselves as a beta test site for a new national dashboard of core measures.

Additional High-Level Recommendations

A number of barriers or challenges the community alliances describe as slowing their progress illustrate situations where they feel NQF also can supply useful resources, connections or support.

For example, the alliances list ***sustainability*** among the challenges they face, especially funding their work as regional or local “conveners” who create a forum for discussion and implement change. Several suggest NQF’s role in this area focus on helping collaboratives develop funding streams to keep programs going and back new ideas.

Newer alliances especially raised the issue of having ***limited staff resources*** to address immediate needs, much less grow. They would welcome assistance from NQF or one of the national healthcare networks to identify strategies for operating effectively “in the field” with such limitations while working to establish a deeper, stronger base.

Other Barriers or Market Issues

We asked alliance leaders surveyed for this paper to pinpoint local, regional and national market issues that act as barriers to their success. As already noted, they identified several top concerns as instances where they suggest NQF can and should provide assistance and support. Presented as high-level recommendations in the previous section, these incorporate issues like the struggle to engage physicians, hospitals and national health plans in quality improvement programs, and maintaining the financial viability of local and regional efforts. The authors identify several issues in this section as “opportunities” where NQF might bring its influence to bear.

This summary of barriers examines a range of other factors that hamper local efforts to introduce standardized performance measures and public reporting. Going down the list of the hurdles they face day-to-day, alliances underscored the value they place on any opportunity to learn how peers in other regions respond to these same challenges. They know they share many in common and appreciate the veracity of solutions percolating across the country.

Weather political change and fiscal woes. The November mid-term election signaled changes in statehouses and legislatures that pose fresh challenges to the work of community healthcare groups. They are dealing with governors and state legislators critical of the national mandate for health care reform and others who talk of altering course on existing, forward-focused initiatives. Recession-battered state budgets continue to jeopardize public programs that are important to community alliances and their partners. And a generally tough economy creates myriad challenges for all stakeholders in a competitive marketplace.

OPPORTUNITY: Help frame the healthcare value issue as non-partisan and one that is central to resolving the impact of health costs on local and state budgets.

In Maine, Rooney predicts the work of nonprofit regional exchanges like Quality Counts may be more difficult now with a change in leadership at the state level.

Mulvey says as the political landscape in New York shifts, NYQA needs to accelerate its efforts to participate in developing an all-payer database that allows the legislature to review information on the quality of public plans. With a possible mandate from new state leaders to create a state-managed all-payer model, the alliance must move quickly to leverage NYQA's viable multi-payer database as a credible existing resource and starting point. Mulvey is monitoring efforts of the CVE in Oregon, now working with its state on a similar project. She hopes to tailor any database expansion to the needs of her collaborators.

Budget issues are huge in California. Yanagihara of IHA says it is a struggle to get and keep health reform visible in such an environment and secure resources related to quality care. She describes the community of people and groups involved in the movement there as small despite the size of the market. Keeping these healthcare quality collaboratives and alliances cohesive and organized enough to have an impact is another aspect of this challenge.

The State of Washington also faces monumental fiscal challenges, says Dade of Puget Sound Health Alliance, and it is distracting for those involved. “It is difficult for state agencies to innovate when so many deep and impactful cuts are taking place,” she notes. In the region’s wider marketplace, where cash-strapped purchasers are shopping for deals, the competition among health plans that partner with the alliance can clash with efforts to foster a collaborative environment. The plans may agree to “work together” as alliance members on most issues, but the need to compete limits their ability to do so in all areas.

AF4Q SCPA’s Christine Amy sees opportunity in the fact that health plans and providers view reporting data as offering a competitive advantage. But it also creates a tenuous relationship among providers, especially with hospitals distracted by a struggle to survive. In this environment, she says, collaboration is at odds with competitiveness. “It is a time of hope and fear.”

Expand the source of data through adoption of electronic records. Improving data sources and data collection—to make them more fact-based and timely—is a challenge for many alliances.

They need to build registries that can manage clinical data and

OPPORTUNITY: Push for standardized approaches from national EHR vendors.

lobby EHR-system vendors to improve the consistency of meaningful use in their products.

Healthy Memphis Common Table considers claims data inadequate for reporting on quality. Executive Director Renee Frazier says they prefer to include chart reviews, a challenge since EHR use in primary care is less than 40 percent in the market currently. And while hospitals do better, they cannot always provide the relevant information.

The Pennsylvania Aligning Forces group, AF4Q SCPA, is trying to get all key players in its market (providers, payers and healthcare collaboratives) to use the same approach. Amy says it took a year to decide on measures related to heart failure and how to have physicians pull records that contain adequate diagnosis and therapy data. Now the alliance needs a registry designed to collect clinical data.

Data ownership is an issue in the west Texas region the Rural Institute at TTUHSC serves, according to McBride. Having standardized national measures makes it easier to achieve collaboration among diverse groups, but she says data sharing remains a problem. Next step is to find a model that shows partners how cooperative agreements benefit all the players.

Getting data good enough for public reporting is an issue for MHI in St. Louis. Probst says their data-focused initiative, formed with support from the business-focused BHC, must balance the interests and concerns of all stakeholders, including physicians, hospitals, labor unions and consumers.

Susan Fenster, Performance Measurement/Public Reporting Team Lead for the P2 Collaborative says available data is not robust or easy to defend as representing the facts. There are systemic problems that implementing electronic records does not solve completely. Fenster notes that coding is an issue, especially with third-party referral sources. They also see problems with accuracy where definitions and methods vary— from sophisticated to obsolete— among clinics and practices that supply data.

Maintain autonomy. It is critical to keep the organization’s independent standing in the region as they promote cooperation and partnership, says Executive Director Hirschberg about the P2 Collaborative. An initiative that organized three major health plans to consolidate 15 years of claims data using comparative standards to report on measures of ambulatory care and produced results on 850 primary care physicians raised the Collaborative’s visibility. They must prevent being seen as “a front for the health plans” or any other group by communicating clearly with all partners.

Secure cooperation from state Medicaid offices. The community alliances depend in varying degrees on the support of their state Medicaid offices, tasked as many are to include the large patient group covered by the federal program in that quality improvement initiatives. Some of the alliance executives report a lack of participation from their state offices, others an administrative maze that slows data sharing processes and reviews.

OPPORTUNITY: Work with national and state Medicaid groups to bridge the divide and encourage collaboration with local alliances.

Achieve and maintain momentum. Private sector cooperatives working locally and regionally are in a unique position to interact with all the stakeholder groups involved in quality improvement. They also see, and deal with, the major challenge of getting everyone in the same place at the same time, prepared to contribute to improvement efforts. Employers feel the effort is moving too slowly, says Rooney of Quality Counts in Maine, physicians feel it is moving too fast. Consumers are barely tuned in, he adds, and everyone is wondering what the health plans will do next.

Commenting generally on the slow pace of progress on regional and national fronts, Rooney compares it with the history of technology advances. “Computers were revolutionary when they replaced typewriters, but we’ve moved light years beyond that today. We need to do the same with quality measures.” More than ten years since the Institute of Medicine report on patient safety, he observes, the country still does not see deaths from medical mistakes as a major public health problem.

Expand collaborative’s reach. For IHIE, motivating employers to influence health plans’ participation in its quality programs presents a challenge, as does engaging insurers to sign up. With the group’s track record of effective data collection and sharing to promote, VPs Shultz and Kansky see the need for targeted, albeit time-consuming outreach efforts.

Probst spotlights similar challenges in her efforts to recruit practicing physicians from various geographic areas within the region to participate in MHI’s Physician Leadership Council. She observes it is revealing to find that physicians often do not know one another and generally lack a common practice connection that might benefit their quality improvement efforts.

Success Factors: Trends and Themes

The groups contributing to this report also highlighted examples of how they operate to meet mission. They described the proactive strategies they follow to influence healthcare change in their communities and the success factors that typify their organizations. First up are strategies that multiple alliances say represent how they interact with partners and the marketplace.

Build Buy-In

Building buy-in among stakeholders is an on-going process, not a singular or point-in-time event. While doing so is a challenge for local healthcare alliances—and one where they welcome assistance at the national level—all of them pursue active strategies of their own to engage key players and members of the wider audience in support of their efforts. A major focus for the collaboratives is securing a strong commitment from hospitals and health plans, and especially from physicians, to adopt quality improvement methods using performance measures and public reporting.

IHIE in Indiana, NYQA in New York State and MHI in St. Louis have physician committees or councils that serve as forums where physicians can evaluate and recommend proposed measures and reporting processes. MHI also sponsors a hospital council to involve decision makers from that sector in advancing the collaborative's efforts.

NYQA considers physician groups and health plans as main partners in a P4P project that began in 2007. The organization formed a Physician Alliance committee as part of the project to help develop "fair, reasonable practices and scoring standards." The committee gives physicians a role in defining the framework of NYQA's measurement resource and helps get these important stakeholders "invested" in the process. Executive Director Mulvey says, "It takes time but in the end, the physicians have ownership of the process and the final reports."

Indiana's well-regarded health information exchange asks physicians and quality professionals from its stakeholder groups to sit on a measures committee that reviews, tests and recommends which measures IHIE will use in its Quality Health First program.

A scenario that stands out as exceptional buy-in is the 12-member Physician Leadership Council advising MHI on quality improvement measures and methods. MHI's Probst says the physicians who participate happen to be strong advocates for quality improvement. They encourage the alliance to accelerate the reporting process beyond primary care to other physician specialties, starting with cardiology and progressing to endocrinology, obstetrics and pediatrics.

Two of the statewide alliances featured in this report, IHC in Iowa and California's IHA, take advantage of being trusted conveners to bring people together. For IHC, a partnership between the Iowa Hospital Association and the Iowa Medical Society, the approach is to have alliance partners identify where they want to be collectively, set expectations and initiate a meaningful dialogue. "That's where change starts to happen," says Dr. Evans.

IHA counts physician groups, hospital systems and major health plans in its membership and strives to give all players a voice. "You can't overestimate the importance of doing that," says P4P Program Director Yanagihara. The result she explains is an atmosphere of trust and common purpose that overcomes individual resistance to the organization's quality improvement and accountability initiatives.

Stakeholder alignment is an important part of building buy-in. Dr. Amundson of Quality Quest in Illinois, says achieving agreement on common goals among the organization's main partners has an impact on improving quality of care and reducing healthcare costs. Despite divergent operational incentives—health plans profit from more enrollments, employers want to manage costs, providers make more by providing more care—she notes that key stakeholders recognize working together is more effective in addressing healthcare quality and value in the region.

The Peoria-based alliance offers an example of persuading providers to invest in change. As it conducts a study of High-Tech Diagnostic Imaging (HTDI) to improve safety and appropriate use, Quality Quest is asking a group of area health plans to switch off the benefit management programs that control pre-authorization and tend to override individual decision making about patient need and alternatives. The strategy is to incorporate a decision support tool instead for choosing diagnostic imaging to learn if the approach improves patient safety and decreases waste. "We need collaboration on this," Dr. Amundsen explains. "It takes a lot to build social capital with providers and convince them patient safety is worth changing the way they practice."

The Puget Sound Health Alliance in Seattle manages performance-data aggregation for the region and takes a proactive approach to expanding beyond existing measures where possible. Central to achieving acceptance of new

measures is engaging all key stakeholders in detailed, extensive discussions. “The group process is part of our sustainability,” notes Director of Performance Improvement Dade. “It involves people in our work, keeps them engaged and interested, keeps the work we do relevant.” The recent work there of a measures group evaluating standards for resource use sets the example.

Correct Reported Data

Reconciliation reports or data correction is a strategy several community alliances say secures cooperation from physicians in performance measurement activities and calms their fears about public reporting.

A secure online reconciliation process that makes corrections at a physician’s request is part of IHIE’s approach. VP for Business Development Kansky says giving physicians a chance to check for errors in patient data associated with their practice is an important key to satisfaction. And, although some dislike the need to pore over data and make corrections, many physicians use what they learn to communicate more with patients and advocate healthy behaviors. The report review also lets physicians see where they score against peers in the market on quality measures.

Hawaii’s HMSA, which offers health plans, employee benefit services and worksite wellness programs, gives physicians participating in one of its P4P programs with access to a dashboard where they can see numerators and denominators on all measures and make corrections.

Recruit Champions

A group of the multi-stakeholder alliances contacted said they rely on alliance members or marketplace partners to promote performance measurement and reporting—to assist with “selling” the concepts. This includes health plans helping physicians understand their role and getting them to cooperate with visible quality improvement efforts. It also involves engaging other constituent groups in providing feedback on methods.

The P2 Collaborative depends on active help from a broad spectrum of partners that include providers, payers and purchasers, hospitals, consumers, businesses, government and many community-based groups. The alliance organizes work groups from its partners to focus on five key areas—including performance

management, quality improvement, health equity, data action and consumer engagement. The strategy gives the Collaborative access to individuals with local knowledge, subject expertise and influence who also serve as a credible link to various constituencies within the community.

Another example of looking for “champions” to promote adoption of measurements, improvement efforts and public reporting comes from NYQA. As part of its efforts to generate enough data to produce meaningful results, the alliance turns to physician groups and health plans among its collaborators to help educate individual doctors about the need to supply data and work with them to streamline the process.

IHA in California works with a statewide quality collaborative partner that offers training, peer-to-peer learning and expert-led programs to group and small practices with a focus improving patient experience, affordability of care and clinical effectiveness. IHA provides the collaborative with data to do targeted outreach.

Other Success Strategies

We highlight here a number of additional activities and approaches individual alliances put to work in their markets with success. While not exclusive to the alliances profiled here, these examples demonstrate the innovative strength of local collaboratives and offer ideas others can adapt to their regions or programs.

HealthCare21 draws membership from three Tennessee cities and considers the state and surrounding region its market. The group organizes local business interests, providers, hospital systems and health plans together around concerns about poor-quality healthcare and skyrocketing costs. President and CEO Burgess says HC21 uses its influence with both purchasers and suppliers of healthcare to persuade hospitals and health plans to supply measures. He hears positive feedback, he says, even from those initially critical of the measurement program. *We started to be a better hospital because of this process* is one response Burgess cites.

Applying robust standardized measures that produce credible data is a goal of every community alliance surveyed for this report. AF4Q SCPA produces a *Community Checkup* for consumers and purchasers in South Central

Pennsylvania with performance information on area providers and hospitals. As part of a strategy to collaborate with good data sources, Executive Director Amy says the Aligning Forces group contracts with a third-party benefit administrator that gathers clinical data from client practices. Their results add strength to the data AF4Q SCPA reports.

For Healthy Memphis, planning and implementing the survey behind a 2009 patient experience report was a major effort that required convincing its partners in the business community, at health plans and individual physicians of the value behind helping consumers take charge of their care. Executive Director Frazier says the first report—which they plan to update every other year—produced solid, transparent data that will contribute over time to the vision of “excellent healthcare for all” that the alliance promotes.

Quality Counts enjoys a strong collaborative relationship with many of its partners. A project the alliance coordinated with the Maine’s agency for quality improvement and the Maine Primary Care Association last year used national measures to inventory “best practices” in ambulatory care. The results identified how many providers use EHRs and other tools to improve quality and efficiency. Quality Counts then helped create a statewide Primary Care Practice Listing to track adoption of best practices and improve communication with providers.

In St. Louis, BHC helped form MHI as a forum for managing and sharing data. Working independently and as partners, both groups benefit from the connection. It engages the employer members of BHC because their dues support the data asset and a collaborative focus, elements the business group see as extensions of its mission to enhance the quality of investments in employee health benefits. MHI is their link to working with physicians who feel purchasers are in a position to have a positive impact on health issues through workplace wellness.

Summary

Many of the community alliances represented in this white paper have reputations for innovation and results that reach beyond their states and regions. All are distinguished by energetic leadership and an unshakable commitment to having an impact on the future of affordable quality care—in their communities and nationally. They are alert to the tenor of the debate on healthcare quality and cost going on in their communities and do their part to contribute reasoned arguments and ideas to the dialogue.

As a group, the alliances recognize that healthcare is local but that reform requires a unified national movement. All have strong links with the national networks and programs they represent, some are NQF members and they actively seek professional connections among colleagues in other collaboratives.

Local collaborative look to NQF for performance measures that represent current respected medical standards. They encourage the organization to expand those they endorse, and simplify composition of and access to all endorsed measures. Weigh in on the national front, they say, to secure support for performance measurement and public reporting from hospital and medical groups that continue to influence their members lack of cooperation at the local level. Be a resource for local alliances, a conduit to help them reach out and learn from groups with similar challenges or opportunities. Listen to what local alliances and collaboratives are accomplishing and involve them in testing new tools and ideas.

The majority of leaders contacted for this report appreciated the chance to advise NQF and put their recommendations into context with stories of challenge and success. But more than one voiced a caution that surveys and white papers not become a substitute for action. The CEOs, executive directors and program leaders who contributed to this paper hope to partner with NQF on moving needed changes in healthcare forward.

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Appendix: Brief Profiles of Featured Community Alliances

Websites and interview notes were primary background sources for the information included in this appendix on each organization that contributed comments for the white paper, *In Support of Regional Healthcare Improvement*.

Aligning Forces for Quality South Central Pennsylvania – York, Pennsylvania

Christine Amy, Project Director

www.aligning4healthpa.org

The Healthy York County Coalition (HYCC) leads this Aligning Forces for Quality project (AF4Q SCPA) and Chartered Value Exchange involves 42 organizations representing hospitals, health plans, physicians and consumers. Other partners include public health agencies, the state medical society, specialty medical associations and a data-source alliance (Pennsylvania Health Care Quality Alliance/PHCQA) that serves the state. WellSpan Health, a nonprofit health system serving York and Adams counties, is an active member.

Every three to five years, HYCC and a partner coalition in Adams County conduct a community health assessment that includes data from health, education and law enforcement sources, and reference data from a US Department of Health and Human Services “healthy people” program. Four provider participants in AF4Q SCPA voluntarily collect data through WellSpan Health’s preferred provider organization, South Central Preferred (SCP). The program measures six nationally endorsed quality indicators of care for chronic illness. Physicians receive reports that compare their performance to that of peers.

A consumer-focused program—the “I Can” Challenge—enrolls patients living with a chronic disease in a multi-week program where they learn how to manage their conditions long term and reduce hospital visits.

AF4Q SCPA is an NQF member. The alliance works with the state quality improvement organization (QIO), which is the REC (Regional Extension Center) for east and west PA, on expanding use of technology. Also involved with the Governor’s Office of Healthcare Reform.

Hawaii Medical Service Association – Honolulu, Hawaii

Richard Chung, MD, Senior Vice President

www.hmsa.com

Independent licensee of Blue Cross and Blue Shield Association. Established in 1938 and one of largest healthcare service organizations in State of Hawaii, HMSA provides coverage for 700,000 people, more than half the state’s

population. The organization offers health plans, employee benefit services and worksite wellness programs. Through a private foundation, it funds community efforts to improve health in the state. HMSA is a Beacon Community participant.

Recent initiatives for improving community health and well being include:

- Practitioner Quality and Service – Evaluate and reward physicians who maintain a high level of patient care and service based on best-practice guidelines that measure healthcare quality, patient safety, patient satisfaction and efficiency. Paid out \$92 million to participating physicians since 1998.
- Hospital Quality and Service – Recognize hospitals for delivering efficient, quality care that focuses on patient safety, and physician and patient satisfaction. Since 2001, awarded Hawaii hospitals total of \$51.7 million for meeting program measures.
- HMO Quality and Performance – Evaluate quality of care and service delivered by practitioners in HMSA's HMO plans. Since 1998, paid health centers across the state \$34.4 million through the Q&P program.

HMSA began three-year program for innovation and quality [HI-IQ] in 2006 that made grants to physicians and eligible hospitals to support improvements in patient care and outcomes through technology. It also helped more than 700 participating providers acquire and implement EHR systems.

HealthCare21 – Knoxville, Tennessee

Jerry Burgess, President and CEO

www.hc21.org

Non-profit organization with 85 to 90 corporate members represents a multi-stakeholder group in three cities: Knoxville, Chattanooga and Nashville. Committed to improving quality and cost of healthcare in Tennessee and surrounding region. Promotes cooperation between employers, health plans, hospitals and providers to achieve changes/improvements in the healthcare of the local community and society as a whole. Works with both the purchasing and supply side of healthcare.

Key focus areas:

- Value Based Purchasing- Consider combination of price, service and quality.
- Performance Measurement- Measure the performance of health plans, hospitals, physicians and brokers.
- Involve the consumer in purchasing to help reduce risk and cost of healthcare.

Regional rollout leader for Leapfrog, HC21 published the first reports on hospital measurements and continues that program with a consumer guide. Member of NQF and the National Business Coalition on Health.

Healthy Memphis Common Table – Memphis, Tennessee

Renee Frazier, Executive Director

www.healthymemphis.org

Nonprofit collaborative founded in 2003 to improve health outcomes and quality of care in Greater Memphis. Funded as an Aligning Forces for Quality organization, HMCT is comprised of 150 groups and 1000 individual partners serving Shelby County. Partners include: “individual consumers, schools, hospitals, physicians, nurses, nutritionists, dentists and other health care providers, medical advocacy and support groups, insurance executives, health plans, quality improvement organizations, colleges and universities, businesses and employers, government, media, youth groups, faith-based organizations and churches, health-, fitness-and recreation-related affiliates, non-profit agencies and foundations.”

Area consumers have experience with measurement since local health plans circulate physician ratings and Medicaid does reports comparing plan performance. Business group HMCT member has history of helping employer/employees evaluate providers for value-based purchasing.

Before receiving AF4Q grant, HMCT concentrated on population health issues (preventing obesity, treating diabetes) rather than quality improvement. The alliance participates in the Network for Regional Health Improvement, identifies as a Chartered Value Exchange and is a member of NQF.

Indiana Health Information Exchange – Indianapolis, Indiana

Chris Schultz, Vice President & John Kansky, Vice President for Business Development

www.ihie.com

The organization was formed by Regenstrief Institute (informatics/healthcare research organization), private hospitals, local and state health departments, a public/private science venture funds group and other Indiana-based healthcare and community organizations. One of the largest health information exchanges in the country, IHIE connects nearly 70 hospitals, long-term care facilities and other healthcare providers in the state. It serves more than six million patients and over 19,000 physicians throughout the country.

Maintains health data that follows the patient and gives providers information for coordinating quality care and improved outcomes. Specific focus on cancer screenings, diabetes care, heart health, asthma care, well-child visits and other care interventions. Involved in efforts to improve state’s poor rankings in leading health indicators, like obesity, smoking, diabetes and heart disease. Leads coalition selected as a Beacon Community in 2010 and run the Chartered Value Exchange, Quality Health First.

IHIE supports the Indiana Network for Patient Care (INPC), which includes data on over 90 percent of the healthcare taking place at hospitals in the Indianapolis area. INPC contains clinical data on over 10 million patients. It gives physicians access to radiology images, EKG readings discharge summaries, operative notes, pathology reports, medication records and other information on their patients.

Provides electronic results delivery service (DOCS4DOCS) that makes lab results, radiology reports, transcriptions, pathology and hospital admissions reports, discharge and transfer reports from all participating Indiana hospitals, physician practices, labs and radiology centers available to physicians' EHR systems free of charge.

Integrated Healthcare Association – Oakland, California

Tom Williams, Exec Director and Dolores Yanagihara, Director, Pay for Performance Program

www.iha.org

Statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in California. IHA members include major health plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical and technology representatives. IHA's principal projects include Pay for Performance, the measurement and reward of efficiency in health care, value based purchasing of medical devices, health care affordability, bundled episode of care payments and prevention programs directed at obesity. Member of Network for Regional Healthcare Improvement.

Manages California Clinical Data Project, or CALINX, a set of standards that specify how stakeholders format and share retrospective data. Includes lab and pharmacy data. Initiated by the California HealthCare Foundation, CALINX came under the IHA umbrella in 2008 and now they encourage and monitor implementation of the standards.

Iowa Healthcare Collaborative – Des Moines, Iowa

Tom Evans, MD, President/CEO

www.ihconline.org

IHC is a partnership between the Iowa Hospital Association (IHA) and the Iowa Medical Society (IMS). The collaborative takes a multi-stakeholder approach to involving physicians, hospitals, insurers, employers, consumers and other community partners who share data and report best practices to "promote a culture of continuous improvement in healthcare." Member of Network for Regional Healthcare Improvement.

Efforts focus on three cornerstones:

1. Align and equip Iowa healthcare providers for continuous improvement.

2. Promote responsible public reporting of healthcare information.
3. Raise the standard of healthcare in Iowa.

IHC publishes an annual *Iowa Report*, summarizing quality, safety and utilization performance measures on all Iowa hospitals, as a statewide aggregated average and range. As of 2010, 118 hospitals voluntarily report to IHC using eight measures. Over 90 percent report in most categories. IHC transitioned from statewide aggregated reporting to hospital-specific reporting for all measures in late 2010.

IHC draws data from CMS Hospital Compare to report on every hospital with statistically significant sample size. Other resources IHC features online include CMS tools comparing dialysis facilities, home health agency performance, nursing home performance and facility-specific info about Iowa hospital services and charges from the IHA Price Point.

New York Quality Alliance – Albany, New York

Betsy Mulvey, Executive Director

www.nyqa.org

This statewide alliance is a Regional Health Improvement Collaborative in the Network for Regional Healthcare Improvement and a Chartered Value Exchange.

Initiated as a two-year Pay for Performance demonstration project funded by the New York State Department of Health to engage physicians and health plans in gathering measurement data from billings that apply a “starter group” of ten HEDIS measures in out-patient settings with the goal of public reporting on quality. Physician groups and health plans are the main partners in this endeavor. Also involves support from the state and cities, including New York City.

Stakeholders include:

- **Physician groups:** *New York Chapter of the American College of Physicians, New York State Academy of Family Physicians, Medical Society of the State of New York, New York Medical Group Mgmt. Association, Hudson Headwaters Health Network Institute for Urban Family Health, Community Health Care Association of New York*
- **Consumer groups:** *American Heart Association Center for Medical Consumers*
- **Business:** *Business Council of New York State, New York Business Group on Health*
- **Other:** *New York Health Plan Association*
- **Multi-stakeholder collaboratives:** *P2 Collaborative of Western New York [also a white paper source], Niagara Health Quality Coalition, New York Diabetes Coalition*
- **Health plans:** *National and regional health plans*

P2 Collaborative of Western New York – Williamsville, New York

Shelley Hirschberg, Executive Director; Tracy Sawicki, Consumer Engagement Team Lead [also with Red Cross]; Susan Fenster, Performance Measurement/Public Reporting Team Lead [also with Clinical Support Services]

www.p2wny.org

The Aligning Forces for Quality group serves eight counties in western New York State. Market has one of the fastest-growing populations of older women, an uneven mix of several urban and many rural communities, many small medical practices, and issues of poverty and healthcare access. The Collaborative is a member of NQF.

P2 has more than 200 collaborative partners that represent providers, payers and purchasers, hospital systems, healthcare consumers, business, government and a range of community groups. Began in 2002 as core partners came together to improve care of patients with chronic diseases by expanding and improving care; enhancing consumer awareness of self care; and developing and promoting community-wide standards for wellness. The coalition evolved into a membership organization with a mix of partners who provide financial and in-kind support.

Five P2 work groups focus on: 1) performance management, 2) quality improvement, 3) data action, 4) health equity and 5) consumer engagement.

Preparing to launch a region-wide CAHPS (Consumer Assessment of Healthcare Providers and Systems) project to assess patient experience with physicians in group practices, individual providers and provider networks. Participates in a Reaching for Excellence project funded by several area foundations. Organized as a forum for “engaging and amplifying the consumer perspective to shape a stronger health care future for Western New York,” project features a site (www.rx4excellence.org) with links to comparative reports. P2’s physician performance report will appear there and on the P2 site.

Puget Sound Health Alliance – Seattle, Washington

Susie Dade, Director, Performance Improvement

www.pugetsoundhealthalliance.org

An Aligning Forces for Quality affiliate that serves five counties. Puget Sound has 160 members representing health plans in Washington State, many large purchasers, many major medical and hospital groups, and a mix of consumer and advocacy groups. Structured to be multi-stakeholder and governed by diverse community partners. Focus on performance measurement and public reporting, payment reform, consumer engagement and performance improvement. A member of NQF.

Publishes *Community Checkup* reports and companion website that highlights provider use of effective care and identifies areas for improvement. Provides comparisons in ambulatory care areas, including diabetes, heart disease, asthma, depression, lower-back pain, generic prescribing and preventive care, as well as inpatient care areas. Expanding in 2012 to include measures of patient

experience in ambulatory settings using CAHPS (Consumer Assessment of Healthcare Providers and Systems Measurement and Reporting) survey data.

Co-sponsor with state hospital association and state medical society on respective quality improvement efforts. These include projects to reduce hospital-centered infections and participation in a virtual learning network for physicians on practice improvements in primary care. Also maintains relationship with state quality improvement organization (QIO), the state's Regional Extension Center (REC). Co-sponsor with Washington State Department of Health and Washington Academy of Family Physicians to implement the Washington Collaborative to Improve Health, a collaborative learning opportunity for primary care practices on the patient centered medical home.

Quality Counts – Manchester, Maine

Ted Rooney, RN, MPH, Aligning Forces for Quality Project Director

www.mainequalitycounts.org

Statewide alliance is coalition of providers, payers, purchasers and consumers founded in 2006. Designated an Aligning Forces for Quality (AF4Q) grantee; also a Chartered Value Exchange and associated with the Beacon Grant to Eastern Maine Healthcare Systems. Member NQF.

Quality Counts collaborates on the AF4Q initiative with Maine Quality Forum (MQF), the state agency for healthcare quality improvement, and an employer-led nonprofit (Maine Health Management Coalition, or MHMC) that reports on performance of all hospitals in the state and about 75 percent of primary physicians. This partnership is central to the collaborative's goals that include strengthening existing quality improvement relationships, aligning and coordinating measurement/reporting efforts, and reforming benefit design and reimbursement.

Programs include:

- Patient Centered Medical Home pilot program involving a group of primary care practices with a long-range goal of statewide implementation of PCMH,
- Behavioral Health Integration initiative that promotes behavioral-physical health integration through creation of targeted performance measures
- Focus on consumer engagement with projects like Maine Diabetes Pathway, information on managing diabetes.

Maine was one of the first states to collect and report on clinical and financial data on all hospital discharges. Maintains database of all outpatient visits and services statewide. MHMC member businesses and employees use an MHMC program (Pathways to Excellence) with performance data on hospitals and primary care physicians to make purchase decisions. Providers and hospitals use the data to identify quality issues; payers use it as basis for incentive programs.

Quality Quest for Health of Illinois – Peoria, Illinois

Gail Amundson, MD, President and CEO

www.qualityquest.org

Part of the Network for Regional Healthcare Improvement, Quality Quest describes itself as a “not-for-profit, independent source for unbiased information on local healthcare.” Caterpillar Inc., a local major business partner, and OSF Healthcare System started Quality Quest in 2006 to address healthcare quality and value in the region. Membership now includes consumers, providers, payers and employers.

The alliance uses quality improvement teams to identify and address specific healthcare issues. They measure and report provider performance with data from participating health plans and insurers to compare findings against best-practice, evidence-based care standards. Quality Quest promotes a shared goal among partners of improving the quality of care in Illinois, reducing waste and getting value for the money spent on care.

Issues *Quality Reports* on cancer screening, asthma care, diabetes care, heart disease care, colonoscopy care and other measures, available to providers and consumers on the Quest website.

St. Louis Area Business Health Coalition/Midwest Health Initiative – St. Louis, Missouri

Louise Probst, Executive Director

www.stlbhc.org

<http://midwesthealthinitiative.org/>

Business Health Coalition (BHC) membership consists of 40 leading employers in the St. Louis region. It was founded 30 years ago to give area employers a collective voice on healthcare issues. Members share the goals of improving employee health and enhancing the quality/value of their investment in health benefits, and support these efforts through advocacy, purchasing solutions and sharing their experiences as part of a health-focused business network. Key strategies are to improve health, achieve transparency and expand incentives. Member of the National Business Coalition on Health.

BHC supported development of the Midwest Health Initiative (MHI), formed over last two years, as a forum for managing and sharing data. MHI stakeholders include physicians, hospitals, employers, labor, insurers and consumers. First task was to create a “de-identified” database of retrospective claims data gathered from employers, unions, health plans and other organizations. Besides start-up funding and in-kind services, BHC continues to provide MHI with administrative and organizational support. Goal of data asset is to provide physicians with meaningful and accurate information on the overall health of their patients.

Texas Tech University Health Sciences Center – Lubbock, Texas

Susan McBride, TTUHSC School of Nursing & Rural Institute REC/West Texas
www.ttuhsc.edu

The Health Sciences Center includes the Schools of Nursing and Allied Health Sciences, and the Graduate School of Biomedical Sciences, part of the Texas Tech School of Medicine based in Lubbock. It is a regional, multi-campus institution that emphasizes “the provision of quality education and the development of academic, research, patient care and community service programs to meet the health care needs of West Texas.” TTUHSC serves 108 counties with a population of 2.6 million people. The institution is designated a Chartered Value Exchange.

Susan McBride is a Professor in the School of Nursing with expertise in informatics and use of metrics in the clinical arena. She teaches courses on how to use biomedical information tools to develop quality measures. She is a senior advisor to the F. Marie Hall Institute for Rural and Community Health based at TTUHSC that is part of national push to adopt health information exchanges through Regional Extension Centers (REC). Before joining Texas Tech, responsible for oversight of a large Collaborative Data Initiative (based at the DFW Hospital Council Education and Research Center) that supports over 70 hospitals in North Texas using data to improve patient safety and quality. The initiative beta tested and used all AHRQ Quality and Patient Safety Indicators pre-dating MONAHRQ. Also involved in major initiative with 13-hospital consortium (Texas Health Resources) using patient safety initiative to improve health. Conducted beta testing of ARHQ software on quality reporting.

Through work with the Rural Institute, the Center at TTUHSC is trying to determine what rural areas need to make the move toward HIE and quality reporting. The group collaborates with other REC grantees at the University of Texas-Houston and Texas A&M. Program targets 66 rural hospitals in West Texas, helping them report HIPPA transactions information and AHRQ quality indicators to the state.