State Quality Improvement Institute:

Overview and Progress Report, Year One

February 2009

AcademyHealth

www.academyhealth.org

Table of Contents

Executive Summary . . . 3
Introduction . . . 4
Overview . . . 4
Why Reform? . . . 6

About the State Quality Improvement Institute . . . 7
Elements of the State Quality Improvement Institute . . . 7
State Action Plans for Change . . . 8
Engaging State Stakeholders . . . 9

Technical Assistance Content . . . 9
Takeaway Strategies . . . 9
Technical Assistance Focuses on Major Policy Issues . . . 10
Delivery and Financing Systems Reform . . . 10
Payment Reform/Purchasing Strategies . . . 10
Care Coordination, Chronic Care Management and Population Health . . . 11
Medical Homes . . . 11
Other Care Coordination and Chronic Disease Management . . . 11
Population Health Strategies . . . 12
Transparency/Data Collection and Reporting . . . 12
Data Integration . . . 13
Performance Measurement and Reporting . . . 13

Conclusion . . . 14
Endnotes . . . 14
Appendices . . . 15
Appendix 1: State Quality Improvement Institute Kick-off Meeting Faculty . . . 15
Appendix 2: State Quality Improvement Institute Cyber-seminars . . . 16
Appendix 3 State Quality Improvement Institute State Profiles . . . 17
Appendix 4: State-Reported Policy Levers and Approaches . . . 32

State Quality Improvement Institute: Overview and Year 1 Progress Report

Executive Summary

The United States continues to experience rising health care costs and gaps in quality of care. In 2007, the Commonwealth Fund released its *State Scorecard on Health System Performance (Scorecard)* using state-specific performance measures in five important aspects of care:

- Access
- Quality
- Avoidable Hospital Use and Costs
- Equity
- Healthy Lives

The *Scorecard* was envisioned as a quality improvement tool to assist states in identifying strengths and weaknesses and to quantify opportunities for improvement. The *Scorecard's* state performance rankings help states target their efforts to improve quality and contain costs.

In 2008, The Commonwealth Fund and AcademyHealth launched the State Quality Improvement Institute (SQII) to complement the *Scorecard* by providing technical assistance for state quality improvement efforts. Through a competitive process, nine states—Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington — were selected to participate in an intensive process of state-level planning and engagement with expert faculty to facilitate their reform efforts.

The SQII facilitated ongoing contact between high-level state participants and expert faculty to support state efforts to improve care in three priority areas: delivery and financing systems reform, chronic care/population health improvement, and data integration/ transparency. Following their start-up planning phase, SQII states began the process of implementing action plans around specific improvement strategies. Important strategies under way in the states include implementation of medical homes and care coordination strategies, adoption of population health initiatives to reduce chronic disease risk in the community, improved chronic disease management to improve outcomes and avoid costly hospitalization and re-hospitalization, and use of data for performance improvement and public reporting. The SQII's expert faculty is working closely with multi-stakeholder state teams to support their efforts to identify and adopt evidence-based models for systemic transformation.

This progress report describes important elements of the technical assistance provided, outlines the efforts of the participating states, and lays the groundwork for revisiting progress at the state level at the end of the State Quality Improvement Institute project.

Introduction

Overview

The United States health care system is troubled by rising costs and variability in the cost and quality of health care services. In 2007, The Commonwealth Fund's Commission on a High Performance Health System released a *State Scorecard on Health System Performance* (*Scorecard*) illustrating state-by-state performance on multiple access, cost, and quality indicators. The *Scorecard* showed dramatic differences in state performance (Exhibit 1). Many states perform consistently above average on indicators of health system performance—yet all states have room for improvement. By closing the gaps between the highest performing and lowest performing states, there is a tremendous opportunity to reduce mortality, improve quality, and control costs.

The Commonwealth Fund's Commission on a High Performance Health System has challenged the federal government and states to move toward high quality, efficient, and equitable care through systemic transformation. Key guiding strategies recommended by the Commission for national reform are:

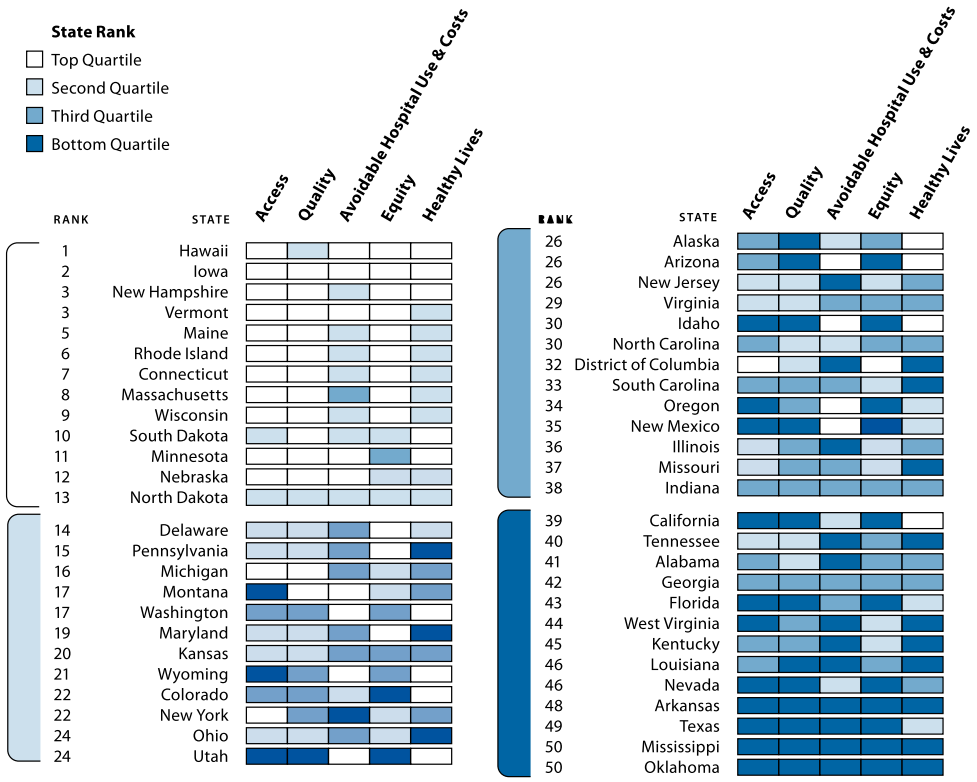
- Extending comprehensive, affordable, and seamless insurance coverage to all;
- Aligning incentives to reward high-quality, efficient care;
- Organizing the health system to achieve accountable, coordinated care;
- Investing in public reporting, evidence-based medicine, and the infrastructure necessary to deliver the best care; and
- Exploring creation of a national entity that sets aims for health system performance and priorities for improvement, monitors performance, and recommends practices and policies.[1]

In 2008, AcademyHealth and The Commonwealth Fund (see Exhibit 2) launched the SQII to help make information presented in the *Scorecard* actionable by states for quality improvement. The goal of the SQII is to assist states that are ready to make or have made substantial commitments to quality improvement, and to facilitate development of concrete action plans for further progress. The SQII serves as a convener to help engage stakeholders—state agencies, health plans, hospitals, payers, physicians and other practitioners, and consumers—in reaching accord on state health quality problems and action items to improve quality. Through the SQII, states are matched with expert faculty with expertise in the areas selected for improvement by state participants. The SQII approach enables states to select improvement targets and access expert technical assistance based on recurring state needs.

States participating in the SQII represent a range of rankings on The Commonwealth Fund *Scorecard* indicators and are at different stages of examining or implementing health care reform. All have made a commitment to developing a state-specific action plan to examine opportunities for systemic changes to drive improved efficiency and quality of care.

- **Colorado** is seeking technical assistance to improve coordination of care in the state. This strategy is seen as essential to improving the quality and efficiency of care for both children and adults. The state is also exploring replication of approaches used in states such as Maine, Minnesota, and Massachusetts to improve collaboration around and implementation of evidence-based practice through use of information, purchasing strategies, and pay for performance.
- **Kansas** requested technical assistance to develop measures and standards to achieve the goal of having true medical homes for enrollees in Medicaid, the State Children's Health Insurance Program (SCHIP), and the state employee health benefits program. The state is also interested in developing tools for examining and improving indicators linked to avoidable hospital

Exhibit 1: State Scorecard Summary of Health System Performance Across Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

costs. The state's approach is to link chronic care improvement and value-based purchasing by demonstrating that appropriate care in cost-effective primary care settings can reduce overall health care system costs while improving population health.

- **Massachusetts** will use SQII technical assistance to further refine its understanding of the current needs and challenges facing the state, in particular the high cost of care and high rate of avoidable re-hospitalization. Their goal is to reduce the overall cost of care in the state. The state has selected several disease-specific indicators (diabetes for preventive care and congestive heart failure for re-hospitalization rates) as a method to pilot strategies that could be used as templates for population-wide initiatives.
- **Minnesota** plans to use SQII technical assistance to develop a plan to accelerate the implementation of recent legislation that addresses quality measurement and improvement (including patient experience and engagement with care), cost containment, and payment reform. The SQII will leverage their efforts by working through public/private partnerships.
- **New Mexico** will use technical assistance to increase the state's understanding of data sources available for decision-making. The Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico will lead a statewide effort to convene and engage key state and local government executives and legislative policymakers, and major providers of both private and public health services.
- **Ohio** will use the SQII opportunity to engage stakeholders who will work together to identify and prioritize health needs and systematic interventions. Technical assistance will help to drive creation or utilization of tools to measure impact, ways to build on existing initiatives, and best practices from other states.
- **Oregon** views the development and alignment of quality metrics as a primary goal of the SQII technical assistance. The assistance will support implementation of a medical home approach consistent with the state's overall reform strategy. Oregon also recognizes a need to orchestrate and align the state's multiple quality-related assets.
- **Vermont** has made substantial progress toward comprehensive reform through the Vermont "Blueprint for Health." The state will engage in SQII activities using the Blueprint as the context for making systems change. Quality improvement efforts will include the development of medical homes, community-based care coordination, public health strategies, and widespread adoption of electronic medical records and patient registries.
- **Washington** will deploy technical assistance from the SQII to strengthen the primary care system through a variety of initiatives that target quality improvement, improved access and capacity, increased affordability, and patient-centered care. The focus of the technical assistance will be to help identify factors associated with successful implementation of a medical home, including provider engagement, information management, reimbursement, and improving care management capability.

Through the SQII, The Commonwealth Fund and AcademyHealth are cultivating a focal point within each state to engage stakeholders and provide leadership for collaborative health care reform. This progress report describes the SQII and articulates elements of transformational change. It describes key systems elements of reform advocated by the SQII's expert faculty and the changes planned by state participants. In 2009, AcademyHealth will report back on the states' progress.

Exhibit 2: About the Sponsors

AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy. AcademyHealth promotes interaction across the health research and policy arenas by bringing together a broad spectrum of players to share their perspectives, learn from each other, and strengthen their working relationships. AcademyHealth seeks to improve health and health care by generating new knowledge and moving knowledge into action. AcademyHealth offers a portfolio of services and projects for states in addition to the SQII. In other technical assistance for states, AcademyHealth has tracked state health insurance reform through the State Coverage Initiatives program (SCI). SCI offers a Coverage Institute and technical assistance to states interested in enacting health insurance coverage strategies. For more information, visit: www.academyhealth.org

The Commonwealth Fund is a private foundation that aims to promote a high performing health system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. The Program on State Innovations aims to improve state and national health system performance by supporting, stimulating, and spreading integrated, state-level strategies for expanding access to care and promoting high-quality, efficient care, particularly for vulnerable populations. For more information, visit: www.commonwealthfund.org

Why Reform?

The case for health care reform at the state and national levels has been made effectively and is not repeated in this progress report. Many of the issues discussed here have been thoroughly examined in reports by The Commonwealth Fund, including its 2006 Framework for a High Performance Health System for the United States.[2]

A brief synopsis of underlying problems in the health care system is offered in Exhibit 3.

States and other payers are positioned to exert leverage as purchasers to increase the value of services provided for dollars spent. This leverage can be better deployed through strategies that address both cost and quality, and that engage all of the participants in the health care system. The SQII encourages states to strategically deploy their purchasing and regulatory leverage, and to consider interlocking strategies for reform of both health care financing and delivery systems.

Exhibit 3: Problems Driving the Need for Reform

Many challenges of the health care system are interrelated—for example, it is difficult to control cost without reducing the new onset of disease or the inefficiencies embedded in the current health care system. States considering reforms recognize the need to develop multi-pronged approaches to reform. Important factors considered by states include:

- **High rates of uninsured:** According to the Kaiser Family Foundation, 45 million non-elderly Americans are uninsured. Lack of insurance is associated with lower access to preventive and chronic care services.[3] It also results in cost shifting to the private sector and is a factor in health care inflation and reduced health status.
- **Access to care:** Many populations do not have access to care for preventive services or management of chronic disease. Reasons for lack of access may include uninsurance, unavailability of providers, or cultural barriers. Lack of primary care access often drives higher use of emergency services and poorer health.[4]
- **Increasing rates of chronic disease:** Forty-five percent of the population has at least one chronic disease. The Centers for Disease Control reports chronic diseases are the leading cause of death and disability, and that much of the burden of disease is preventable.[5] Prevalence of chronic disease including diabetes and heart disease is rising,[6] along with preventable risk factors such as obesity, and non-preventable risk factors such as age. The obesity trend is accelerating: more than 65 percent of the population now are considered overweight or obese.[7] Without strategies to reduce risk, prevent disease and to manage diseases more effectively to prevent complications, costs of care will continue to spiral upwards. Strategies for preventing chronic disease are needed at the population, provider, and patient levels.
- **Gaps and variations in quality:** Researchers have shown significant variations in the quality of care delivered across medical conditions, with high quality care being delivered only an average of 50 percent of the time.[8] In many cases, poor quality of care accounts for higher rates of complications and higher cost. In multiple studies to examine regional cost variation and the underlying factors of the variation, researchers at Dartmouth Medical School have shown that variations in spending are highly associated with variations in supply, and that higher spending and utilization are not correlated to better outcomes.[9] The Dartmouth team has concluded that a fragmented care management system has lead to high overall health services utilization without commensurate improvements in health outcomes.[10]
- **Increasing costs:** The costs of health care services are increasing and health care as a percent of state spending is steadily rising. State spending on health increases on average 5 percent per year, with states spending between 8 and 20 percent of state budgets on health care.[11] A significant portion of costs could be avoided by preventing underlying health problems and reducing inefficient or wasteful practices.[12]
- **Misaligned incentives:** Reimbursement systems for health care services promote the use of more care and higher intensity care, rather than coordinated, patient-centered interventions.[13] Physicians and hospitals that adopt more efficient practices and reduce the volume of visits actually may lose income rather than reap rewards for better care. Providers have not typically monitored their performance on efficiency or clinical metrics, and have not been deeply engaged in competitive strategies to improve. Competition based on price and quality, routine in other sectors, rarely happens in the health care market. Initiatives such as pay-for-performance and some medical home strategies have attempted to align payments with higher-quality, better-coordinated care.[14]
- **Insufficient information for decision-making:** At all levels of the health care system—patients, providers, and the government—there is limited information on the cost and quality of services. Neither patients nor payers have sufficient information to select high quality providers.[15] Underlying factors include immature performance measurement strategies,[16] limited use of information technology, and siloed, rather than inter-operable, information systems.

About the State Quality Improvement Institute

Elements of the State Quality Improvement Institute

The SQII is an intensive technical assistance program designed to help states plan for concrete improvements in health care delivery systems. Recommended approaches include value-based purchasing, data collection and transparency, care coordination, disease prevention and population-based health promotion. The nine participating states—Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington—were selected through a competitive process using criteria described in Exhibit 4.

Following a call for proposals, an independent panel reviewed the state applications and determined that the nine states selected had the combination of commitment, leadership, and resources necessary to build on successful efforts in the area of health care quality and to achieve substantive additional reforms. Resources provided from the SQII include:

- **State site visits.** A team from AcademyHealth and The Commonwealth Fund visited each state to help coalesce stakeholders and begin the planning process.
- **National Technical Assistance Conference (Kick-off Meeting).** States were funded to bring teams of up to eight members to a national technical assistance meeting in June 2008. Technical assistance was provided through group and individual state sessions.
- **Roster of technical assistance experts.** AcademyHealth identified thought leaders from the state and national levels to engage with state teams during the Kick-off Meeting and during the course of the project. These subject matter experts offered concrete examples where innovations have been adopted at the state or national levels; they also offered individualized feedback to SQII states (see Appendix 1 for listing of expert faculty).
- **Distance-learning.** AcademyHealth continues to host a series of "cyber-seminars" to help states drill down into specific areas of systems change (see Appendix 2 for cyber-seminar descriptions).
- **Monthly email progress updates and bi-monthly calls with team leaders.** This ongoing flow of information enables AcademyHealth to target technical assistance through expert faculty, based on immediate state needs, and to help states share their progress, challenges, and lessons learned.
- **Action planning.** States are expected to develop specific action plans and to refine them in several stages. The state action plans incorporate activities by multiple

Exhibit 4: About the SQII Selection Process

Requirements for States:

- Each state team must include an overall leader designated by its governor.
- Team members must include executive and legislative policymakers and key program administrators.
- Team composition may include necessary public and private organization representatives.
- States must show commitment of team participants for the duration of the program.
- States must show commitment of state resources to implement quality improvement initiatives.

Selection criteria: AcademyHealth and The Commonwealth Fund selected qualifying states to participate in the SQII based on the following criteria:

- Support from the governor and designation of an appropriate team leader.
- A proposed team that reflects capability to address goals laid out in the application.
- Clearly articulated goals for improvement based on existing performance metrics from the *Scorecard*.
- Proposed innovative approaches to address the chosen quality improvement indicators that examine state policy levers relating to value-based purchasing, data reporting, care coordination, and promoting wellness/disease prevention.
- Demonstrated ability to mobilize key state officials and other community stakeholders.
- Presence of organizational structures to accomplish the objectives of the SQII (e.g., interagency task force; health care commission).
- Demonstrated ongoing commitment to implementing the strategies developed during the SQII.

Additional state information can be found on the State Quality Improvement Institute Web site: www.academyhealth.org/state-qi-institute/index.htm

stakeholders and outline a timeframe for achieving milestones.

- **Implementation of action plan activities.** For the duration of the State Quality Improvement Institute, states are committed to participating in Institute technical assistance activities, reporting on progress, and meeting the milestones established in their action plans.

State Action Plans for Change

States participating in the SQII have made significant commitments to the project. States participating in the SQII vary in population sizes, geographies, and approaches to health care reform. Each state, however, recognizes the need to examine the "levers"—positive and negative incentives that drive behaviors—by which reform can be enacted.

Through the application process, states engaged in planning and development to select a subset of *Scorecard* measures as targets for quality improvement. Prior to entering the SQII program, several states, including Massachusetts, Vermont, Minnesota, and Oregon had begun the process of comprehensive health care reform. These states are using technical assistance from the SQII to help integrate

Exhibit 5: Initial Scorecard Measures Selected by States

Indicator	States
Percent of Adult Diabetics Who Received Recommended Preventive Care	CO, MN, NM, OH, VT
Percent of Children with a Medical Home	CO, KS, OR, WA
Percent of Adults Age 50 and Over Who Received Recommended Screening and Preventive Care	NM, OH, VT

State performance on Selected Scorecard Indicators

2007 Scorecard: Percent of Adult Diabetics Received Recommended Preventive Care*		2007 Scorecard: Percent of Children with Both a Medical and Dental Preventive Care Visit in the Past Year*		Scorecard 2007: Percent of Adults Age 50 and Older Who Received Recommended Screening and Preventive Care*	
Best	65.4%	Best	74.9%	Best	50.1%
MN	58.9%	MA	74.9%	MN	50.1%
NM	50.3%	VT	70.7%	MA	46.7%
CO	50.2%	OH	61.3%	VT	44.4%
MA	48.9%	KS	60.7%	WA	42.0%
WA	48.5%	WA	60.5%	CO	41.2%
VT	47.2%	CO	57.7%	OR	40.0%
KS	43.2%	NM	55.3%	KS	39.7%
OH	39.2%	MN	55.0%	NM	38.7%
OR	NA	OR	52.2%	OH	38.1%
Median All States	42.4%	Median All States	59.2%	Median All States	39.7%
SQII Priority for: CO, MN, NM, OH, VT		SQII Priority for: MN, NM		SQII Priority for: NM, OH, VT	
2004 data*		*2003 data		* 2004 data	

their efforts across priority areas to impact multiple indicators of quality. Other states participating in the SQII selected more discrete health care indicators. During the planning process of the SQII, all of the states recognized the interrelated nature of information management, payment processes, quality improvement, and access on improving health care outcomes. Each state committed to addressing these factors in quality improvement activities. A more detailed description of the SQII states is available in Appendix 3. Exhibit 5 shows the measures most frequently proposed by SQII state participants along with their rankings on selected indicators.

Through the SQII's technical assistance, states examined factors influencing health care and cost outcomes at the state level, and are implementing improvements to impact specific quality measures. Each state has:

- Convened a high level team sanctioned by the governor. Teams could include the governor's health policy advisor, the health and/or health services department secretary, the Medicaid director, the insurance commissioner, legislators (or staff), and the state employee health plan administrator. Many states also included representatives from private payers, health plans, major purchasers/employers, and the advocacy community, as well as representatives from the medical provider community, including hospitals, physicians, and other practitioners.
- Developed a draft and final action plan that identifies specific quality indicators that can be used to identify progress and benchmark successes. Each action plan also includes specific process steps for achieving results.
- Participated in onsite and electronic technical assistance opportunities provided by AcademyHealth for individual states and for all of the SQII participants.

Engaging State Stakeholders

Prior to the start of the program, participating state teams represented varying levels of engagement from health care stakeholders, including physicians, hospitals, the state legislature, consumers, and state agencies. Either before or as a result of the SQII Kick-off Meeting, all of the states created a process for engaging stakeholders to assure that reforms are enacted with the support of key constituents. For example, participating states have implemented the following approaches:

- Minnesota has a history of collaborative experimentation in cost and quality innovations. In 2004 the state created a public/private purchasing consortium called the SmartBuy Alliance. The state also engaged stakeholders in a 2007 reform initiative through a Governor's Transformation Task Force and the Legislature's Health Care Access Commission. These multi-stakeholder engagement initiatives resulted in successful passage of comprehensive reform legislation in 2008 that has become the platform for the state's Quality Improvement Institute work.
- Ohio conducted an intensive assessment of state resources, stakeholders, and health status indicators and convened an Ohio Health Quality Improvement Summit as part of their SQII initiative. The SQII Team is pursuing a strategy to coalesce diverse stakeholders around a portfolio of interventions to enable short-term and long-term return on investment, be actionable by a wide array of public and private stakeholders, and be informed by the multiple local initiatives. The Ohio Summit, which took place November 17-19, 2008 engaged stakeholders in identification of the top 12 strategies that will transform Ohio's health care system into a high quality, cost-effective, high-performing system.
- Kansas's legislature in 2007 required the Kansas Health Policy Authority (KHPA) to convene a deliberative process to make recommendations on health care reform. Health reform recommendations delivered to the governor and the legislature on November 1, 2007 were built on a platform of stakeholder feedback and support. The recommendations were the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned Kansans. Going forward, Kansas is using the SQII process to begin to define and operationalize a new legislative mandate to include medical homes in the Medicaid program and the state employee plan. Kansas will seek stakeholder engagement in defining a medical home in statute and examine purchasing strategies that provide payment incentives for coordinated care and wellness.

Technical Assistance Content

Takeaway Strategies

Technical assistance provided by AcademyHealth and The Commonwealth Fund encouraged states to link quality improvement with state purchasing approaches. The June 2008 Kick-Off Meeting offered all of the state teams an opportunity to examine interrelated problems in the health care system and hear from each other and expert faculty about potential solutions.

The technical assistance framework offered to SQII participants posits that cost control must embody an array of purchasing strategies that reduce demand for services (by creating a healthier population), reduce the volume of services (by reducing inefficiency and increasing coordinated care), and improve the quality of care by promoting coordinated, evidence-based, patient-centered care for acute and preventive services. This framework is consistent with the recommendations of The Commonwealth Fund's Commission for a High Performance Health System.

Overarching messages from experts involved in providing technical assistance about what makes state adoption successful/effective include:

- States have an important role to convene stakeholders with an interest in cost and quality.
- Stakeholders need to be involved in a meaningful way in the development process.
- Policy development and clinical practice improvement are interrelated; both policy change and clinical improvement are needed.
- Pilot programs are effective for testing concepts at the local level that could be expanded statewide.
- States can learn from each other to identify models for reducing gaps in quality.
- Alignment of payment and incentives are needed to promote the desired consumer, provider, and purchaser behavior.
- Robust analysis of data is needed to identify trends and opportunities for system improvement.
- Better approaches to care coordination—such as those included in a medical home—can introduce efficiencies and enhance patient engagement in health.
- Care coordination is an approach to reducing health care disparities and improving population health.
- Providers (physicians, hospitals and other practitioners) need support to deliver care more effectively, including financial resources, information technology resources, and technical support for practice improvement.
- Measurement, feedback and evaluation are essential for all participants in the health care system.

Technical Assistance Focuses on Major Policy Issues

The following section captures some of the important themes that have been examined thus far through SQII technical assistance (see Appendix 4 for policy levers and approaches being used by participating states).

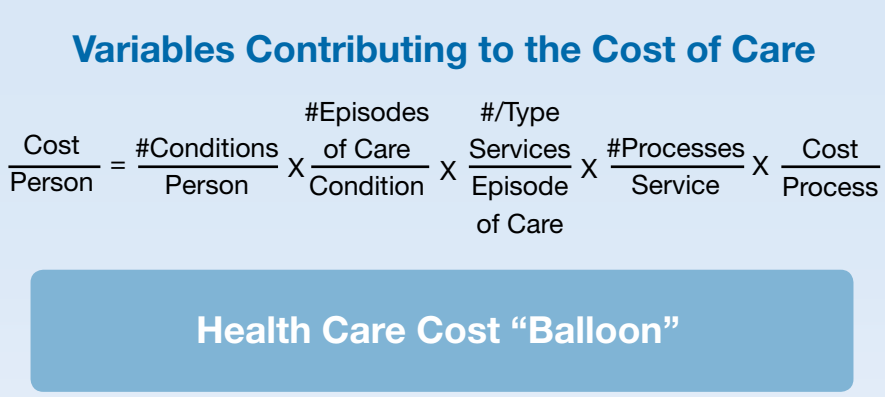
Delivery and Financing Systems Reform

Payment Reform/Purchasing Strategies: The U.S. health care system is composed of many inter-related parts. As financing expert Harold Miller, M.S., of the Pittsburgh Regional Health Initiative explained to SQII participants, variables contributing to health care costs include the people, the number of health conditions per person, the cost of services to care for each condition, and the number of episodes per condition during which care is provided. This equation is graphically illustrated in Exhibit 7. Mr. Miller noted that state or federal efforts to control costs in one part of the cost of care continuum typically result in the growth of costs in another area, as if the state had pushed on one side of a balloon, only to see another part of the balloon swell.

Mr. Miller and other experts concluded that simultaneous efforts are needed to slow the pipeline of individuals needing chronic care, change payments to reward effective and efficient care, and improve quality of care. Faculty experts at the Kick-Off meeting worked with individual states to demonstrate that payment reform is one part of an overall purchasing strategy. They recommended that states use their leverage as purchasers to effect change; each state should go through an exercise to identify what value means in health care and how that translates into the state's approach to buying, creating incentives, and using cost and quality measures.

Elliott Fisher, M.D., M.P.H, of Dartmouth Medical School provided information to SQII participants showing that a significant proportion of health care costs are driven by inefficiencies and unnecessary variations in the health care system. Dr. Fisher used the Dartmouth Atlas data to show that rather than improving outcomes, receiving a high volume of health services reduces health care quality and patient satisfaction. Care volume is driven by availability of specialty services and providers, rather than by patient health needs. Analysis of these problems led Fisher to advocate for changes in the payment methodology from fee-for-service to a bundled care approach, which pays for an episode of care rather than a single service. States were encouraged to consider ways to pay more for higher quality care rather than just rewarding volume.

Exhibit 7: "The Health Care Cost Balloon"



SOURCE: Harold D. Miller, NRHI, PRHI

Care Coordination, Chronic Care Management, and Population Health

Medical Homes: Technical assistance provided through the SQII was designed to bolster state strategies to enhance availability of "medical homes." While there is no universal definition of a medical home, Sarah Hudson Sholle, Dr.Ph., National Committee for Quality Assurance (NCQA), outlined essential elements of a medical home as defined by NCQA. According to NCQA, important components of a medical home include:

- Standards for communicating with patients and offering timely access;
- Availability and use of data to track patient communications and interventions;
- Use of tools—paper or electronic—to track patient information including interventions, health status, and laboratory tests;
- Use of data (such as registries) to track patients by diagnosis or condition;
- Implementation of evidence-based care management guidelines;
- Offering programs to educate, support, and engage patients in caring for their health needs; and
- Measuring performance at meeting guidelines and taking action to improve delivery of care.

The NCQA model provides one set of benchmarks by which states can recognize and reward physicians who incorporate various aspects of a medical home into their practice. NCQA notes that alignment of financing and practice support are necessary to reflect the costs associated with a higher intensity of care delivery and the physician office restructuring that underpin an effective medical home. Enhanced payments for medical homes will incentivize more coordination of care, rather than encouraging a high volume of care as is now rewarded. Medical homes are anticipated to be a cost effective investment to avert use of higher-cost services.

Faculty member Michael Bailit, founder of Bailit Health Purchasing and a consultant to government agencies, discussed the importance of linking payment to practice improvement. As an example, he talked about a project he is supporting in Pennsylvania. He noted that, in Pennsylvania, physicians must meet practice characteristics criteria for a medical home to be eligible for significantly increased payments. These payments specifically support the development of a primary care team that is physician-led and patient-centered. In the Pennsylvania model, payments will be reduced over time as infrastructure is developed and more physicians are eligible for pay-for-performance incentive payments based on outcomes. Payments in the first years of the program are viewed as an infrastructure investment. Of note, physicians in the program are required to treat all patients as medical home patients, not to distinguish by patient or insurer. In practice this means the medical home concept is embedded in the practice through care coordinators or case managers to carry out the enhanced coordination activities.

Faculty members emphasized that successful implementation of medical homes requires robust physician level data systems to track and monitor patient status. Medical homes are viewed as a potential way to reduce health disparities by enabling physicians to identify needs and provide the intensity of care needed by various populations.

Several states participating in the SQII are developing state-level consensus on the definition of a medical home and on payment policy. Colorado, Kansas, Oregon, Vermont, and Washington are conducting pilot testing of medical home interventions to improve care coordination and outcomes. States are collaborating with health plans and physicians to examine opportunities to use medical homes to improve coordination and outcomes. As part of the SQII action plans, states are defining the medical home concept, identifying ways to engage the state's physicians, and conceptualizing reimbursement incentives.

- **Washington State** adopted legislation in 2008 to expand use of medical homes. The state will build on its history of collaboration with stakeholders and widespread agreement on elements of the "Chronic Care Model." Medical home activity will focus on defining the concept of the medical home to underlie subsequent development of performance measures and an associated reimbursement system and incentives for improved performance. Improving the patient experience with the health care system and thus more fully engaging in care is another important element of the Washington plan. Technical assistance from the SQII will help the state learn from other state models, adopt evidence-based practices, and design performance and evaluation metrics.

Other Care Coordination and Chronic Disease Management: Faculty member Ken Thorpe, Ph.D., of Emory University noted that approximately 75 percent of health care spending nationally is linked to patients with one or more chronic conditions. About two-thirds of the growth in spending is due to a rise in prevalence of treated disease. For example, the increase in diabetes spending alone represents a five percent increase in health care spending. Dr. Thorpe reported that the Centers for Disease Control and Prevention (CDC) found that about 80 percent of cardiovascular risk factors are preventable through lifestyle, diet, and quitting smoking. Dr. Thorpe advocated that states both work to prevent chronic disease and to improve quality of care as integral strategies to improve health.

In addition to improving chronic care in ambulatory settings to avoid hospitalizations, reduction of preventable re-hospitalization has emerged as an important focal area amenable to change. Amy Boutwell, M.D., an expert from the Institute for Healthcare Improvement (IHI), engaged SQII states in a discussion of how to use data to identify preventable re-hospitalizations, and approaches to reducing re-hospitalization rates. She noted that 17 percent of hospitalized Medicare patients are re-hospitalized within 30 days, costing that program alone $15 billion per year, $12 billion of which may be preventable. Dr. Boutwell focused on using hospitalization as a sentinel event indicating a highly sick person who may need more care coordination to reduce subsequent re-hospitalizations. The IHI has developed models for reducing preventable re-hospitalizations through improved discharge planning, enhanced communications, and coordinated handoffs of patients from hospitals to ambulatory care providers.

Several states participating in the SQII embraced the goal of improving coordination of acute care services to reduce costs by avoiding complications and exacerbations of chronic disease. Others focused specifically on reducing preventable re-hospitalizations, which can be identified using available data and can be used to identify care management improvement opportunities in inpatient and outpatient settings.

- **Massachusetts**, in its final action plan, has established a goal to improve the quality of transitions of care (hospital discharge) to reduce hospital readmissions. The state will develop pilot programs in hospitals to improve care of chronic conditions and reduce readmissions, and will partner with other stakeholders such as the Massachusetts Hospital Association. The state will use data to identify the top 10 conditions with high readmission rates and will identify and pilot evidence-based hospital discharge plans that improve the transition of care for specified conditions, using congestive heart failure (CHF) as the sentinel condition for process improvements.

Population Health Strategies: States increasingly recognize the need to marry public health and acute care interventions to slow the growth in demand for health care services. Population-based health interventions are expected to improve the health of the entire population. SQII technical assistance focused on ways that states can improve overall health of the state populations. For example, faculty member Joseph Thompson, M.D., the Arkansas Surgeon General, highlighted Arkansas' multi-pronged strategy to combat rising rates of childhood obesity. Using state-specific data from multiple sources, Arkansas built the case for stakeholders that obesity is a driving factor in overall health care costs and morbidity.

In Arkansas as elsewhere, childhood obesity is filling the pipeline with a generation of individuals with poor health, lower quality of life, and higher health care costs. Dr. Thompson pointed out that Arkansas pays for the costs of obesity in its state employee insurance program as well as in Medicaid, SCHIP, and other public programs. With data from the state employee insurance program, Arkansas began by relating employee behavioral risk factors to actuarial risk. As a result, the state adopted an innovative insurance design to incentivize risk reduction. The Arkansas state employee plan adopted first dollar coverage for preventive care, offered discounts for employees with no risks, and adopted incentives for individuals to reduce risk. The purchasing strategy layers on to a public health-oriented prevention strategy enacted in prior years. In 2003, Arkansas enacted enabling legislation to coordinate statewide, multi-sector efforts to combat obesity. The legislation encourages schools to adopt physical fitness programs and healthier menus, and establishes a measurement and tracking program for evaluation of children's body mass index. The Arkansas example illustrates tactics to both reduce future demand for health care services and change the trends for current at-risk populations.

Several states participating in the SQII embraced the concept of promoting population health as a cost management tool by building linkages to the public health systems.

- **Minnesota** recently enacted comprehensive health care reform that, among other things, establishes a statewide health improvement program to reduce obesity and tobacco use and other problems that impact the rates of chronic disease.

States also recognized that, in addition to reducing the long-term cost of services, quality improvements must be driven by addressing the health of the population – and thus reducing the number of people who need the services.

- **Vermont** used its "Blueprint for Health" to stimulate a culture of prevention, or "Community Activation" across Vermont. The Blueprint supported the development of community prevention programs in both Blueprint and non-Blueprint communities. These programs are designed to reflect local input based on local resources and needs. Examples include exercise and walking programs, community walking maps, structured information for patients and providers oriented toward healthy lifestyles, enhanced smoking cessation efforts and other initiatives. The state is seeking to create a cultural transformation and a sustainable prevention infrastructure.

Transparency/Data Collection and Reporting

States are recognizing that, at all levels of the health care system, effective management of data and information is essential to accountability. "Transparency" is the term used to convey the concept that patients, physicians, and payers (including the state) should have access to comparative cost and quality information

that will help them make better health care decisions.

SQII technical assistance focused on identifying potential methods to link information in meaningful ways and translating data into actionable information. SQII participants recognized that better use of clinical information in physician decision-making supports practice-level improvements. At the level of systems accountability, experts encouraged SQII participants to use plan-, state- and national-level data to examine statewide health trends and to drive value-based purchasing.

Data Integration: A model for state-level integration of data was presented by Anthony Rodgers, Director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program. Mr. Rodgers described the AHCCCS data integration initiative, which was developed to provide better information for evidence-based decision-making. Arizona is creating a statewide all-payer data exchange to underpin future state reform activities, starting with the AHCCCS program. The state's goal is to integrate data across the continuum of care from ambulatory to inpatient and long term care. In addition to its current all-payer claims data base, the AHCCCS program has a goal to incorporate information on the patient perspective through "experience of care" surveys and other data sources. Arizona uses integrated data to examine system trends such as over- and under-utilization of medical services, and to increase accountability of purchasing. As a caveat to other states, Mr. Rodgers noted that the interplay of policy, politics, market conditions, and management operations impact the capability of state programs to integrate and analyze data sources.

Several SQII states have tied their reform activities to improved use of data and increased transparency of information.

- **Kansas** incorporated the use of data as a fundamental premise in its health policy activities. Data are focused upon the six principles: access to care, quality and efficiency in health care, affordable and sustainable health care, promoting health and wellness, stewardship, and education and engagement of the public. Kansas SQII activities will focus on medical home implementation using a data-driven approach to defining the content and reimbursement strategy for medical homes. The state convened the Kansas Medical Home Planning group charged with examining data for high-cost diagnoses for Kansas Medicaid and the State Employee Health Benefit plan. By linking data and best practice information to its medical home pilot, Kansas intends to implement a medical home model that will result in measurable improvements of targeted health care indicators.
- **Vermont** used its Blueprint for Healthy Vermont as the vehicle to create an infrastructure to collect data from multiple levels in the health care system (medical records, claims, and laboratory values) and to produce integrated information for decision-making. Vermont strategies include the development of registries, independent chart review to assess physician performance, and evaluation. Vermont has also taken a leading role to expand the use of electronic medical records (EMRs). In 2008, the state implemented a systematic health information exchange infrastructure. As this platform is expanded, it will include a Web-based clinical tracking system, shared data management and analyses, and multi-payer claims. This data system will be used to inform and evaluate Vermont's medical home pilot program. To facilitate adoption of information technology, Vermont established a loan and grant program to help physicians cover capital investments in electronic health record systems in Blueprint communities.

Performance Measurement and Reporting: Increasingly, states are looking at data and information as a way to fully engage consumers and physicians through comparative reporting. Faculty member Tim Ferris, M.D., M.P.H., of the Mass General Physicians Organization, and a senior scientist in the Partners/MGH Institute for Health Policy, highlighted the need to develop meaningful performance measures and to use them in a collaborative manner to support physicians and other providers in making changes. Measurement must be linked to incentives and rewards that will engage participants in a collaborative manner. Ernie Moy, M.D., M.P.H., of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ), identified a number of resources available to assist states in developing comparative reporting tools at the state, community, health plan, and hospital level.

SQII states are working toward making available comparative information on plans, hospitals, and physicians to both promote quality improvement in the provider organizations, and to help consumers make selection decisions based on value. Consumer experience is seen as an increasingly important measurement due to its potential to "engage" consumers in comparative shopping for quality and cost. Physician engagement is important to drive competition on the basis of quality and efficiency.

- **Minnesota** engaged physician groups in self measurement and improvement through the Minnesota Community Measurement (MCM) initiative, and will continue to promote transparency as an important bedrock of value-based purchasing. Physician-lead measurement has been an effective strategy for getting buy-in and establishing credibility of measurement efforts. Minnesota's goal is to provide real-time measurement feedback to physicians linked with clinical prompting through EMRs. This will enable physicians to see their performance results immediately rather than seeing a report six months later. Purchasers in the state believe that transparency is critical to value-based

purchasing by consumers, plans, and the state. The state attributes success of the MCM initiative to the willingness of purchasers to establish performance standards and pay-for-performance programs. Minnesota is working to achieve a statewide goal in which better performance is paid more than lower performance by tying reimbursement to performance levels.

Conclusion

States are leading the way in implementing reforms to address the intertwined problems of rising costs, gaps in quality, and a progressively less healthy U.S. population. AcademyHealth and The Commonwealth Fund are collaborating with states to provide evidence-based technical assistance to enhance their efforts. Technical assistance is organized around the themes of improved purchasing strategies, improved chronic care management and the prevention of disease, and increased availability of data for decision-making. The nine states participating in the SQII are trying a spectrum of approaches. All have recognized the need for reforms, and are working to engage important stakeholders—purchasers, providers, health plans, patients and policy makers—to promote system-wide transformation. By helping the states orchestrate their efforts, the SQII will promote alignment, innovation, and hopefully, large scale improvements at the state level.

Endnotes

1 The Commonwealth Fund Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, November 2007. Accessed at www.commonwealthfund.org/publications/publications_show.htm?doc_id=584834 on February 19, 2009.

2 The Commonwealth Fund Commission on a High Performance Health System, Framework for a High Performance Health System for the United States, August 2006. Accessed at www.commonwealthfund.org/usr_doc/Commission_framework_high_performance_943.pdf?section=4039 on February 19, 2008.

3 Kaiser Commission on Medicaid and the Uninsured. "The Uninsured and the Difference Health Insurance Makes. Fact Sheet," September, 2008. Accessed at: www.kff.org/uninsured/upload/1420-10.pdf on February 19, 2009.

4 Committee on the Future of Emergency Care in the United States Health System. "Hospital-Based Emergency Care: At the Breaking Point," Institute of Medicine National Academy Press. Washington, D.C. 2006.

5 U.S. Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion. Accessed at www.cdc.gov/nccdpho/index.htm on February 19, 2009.

6 Thorpe K. et al. "Which Medical Conditions Account For The Rise In Health Care Spending?," *Health Affairs*, August 25, 2004, pp. W437-45. Accessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.437v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=thorpe&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT on February 19, 2009.

7 Flegal K. et al. "Prevalence and Trends in Obesity Among US Adults 1999-2000," *Journal of the American Medical Association*,Vol. 288, pp.1723-27.

8 McGlynn, E. et al. "The Quality of Health Care Delivered to Adults in the U.S.," *New England Journal of Medicine*, Vol. 348, No. 26, pp. 2635-45.

9 Fisher E. et al. "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, Vol. 138, No. 4, pp. 273-87.

10 Wennberg, J. et al. "Tracking the Care of Patients with Severe Chronic Illness. The Dartmouth Atlas of Health Care 2008 (Executive Summary)," The Dartmouth Institute for Health Policy and Clinical Practice, April, 2008. Accessed at www.dartmouthatlas.org/atlases/2008_Atlas_Exec_Summ.pdf on February 19, 2009.

11 Kaiser Family Foundation State Health Facts. Accessed at www.statehealthfacts.org/comparemaptable.jsp?ind=598&cat=5 on October 5, 2008.

12 Wennberg, J. et al. "Tracking the Care of Patients with Severe Chronic Illness. The Dartmouth Atlas of Health Care 2008 (Executive Summary)," The Dartmouth Institute for Health Policy and Clinical Practice, April, 2008. Accessed at: www.dartmouthatlas.org/atlases/2008_Atlas_Exec_Summ.pdf on February 19, 2009.

13 Committee on the Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Institute of Medicine National Academy Press. Washington, D.C. 2001.

14 Berenson, R. et al. "A House Is Not a Home: Keeping Patient at the Center of Practice Redesign," *Health Affairs*, Vol. 27, No. 5, pp. 1219–30.

15 Collins, S. and K. Davis. "Transparency in Health Care: The Time Has Come," The Commonwealth Fund, March 15, 2006.

16 Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs. "Performance Measurement: Accelerating Improvement," Institute of Medicine National Academy Press. Washington, D.C. 2006.

Appendix 1: State Quality Improvement Institute Kick-off Meeting Faculty

During the June 2008 Kick-off Meeting, 12 expert faculty from think tanks, academia, consulting firms, and state and federal agencies provided in-depth technical assistance to the state teams. These health services and policy researchers encouraged state teams to think creatively about how to go about designing their quality improvement efforts, and demonstrated their extensive experiences and knowledge throughout the meeting. Expert faculty included:

- **Michael Bailit** – Principal, Bailit Health Purchasing LLC
- **Amy Boutwell, M.D., M.P.P.** – Content Director, Institute for Healthcare Improvement (IHI)
- **Timothy G. Ferris, M.D., M.Phil, M.P.H.** – Medical Director, Mass General Physician's Organization; Senior Scientist, Partners / MGH Institute for Health Policy
- **Maulik Joshi, Dr.P.H., M.H.S.A.** – President & CEO, Network for Regional Healthcare Improvement (NRHI)
- **Neva Kaye** – Senior Program Director, National Academy for State Health Policy
- **Harold Miller** – President, Future Strategies, LLC; Strategic Initiatives Consultant, Pittsburgh Regional Health Initiative and the Jewish Healthcare Foundation, Pittsburgh; Adjunct Professor of Public Policy and Management, Carnegie Mellon University's Heinz School of Public Policy and Management
- **Ernie Moy, M.D., M.P.H.** – Medical Officer, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ)
- **Anthony Rodgers** – Director, Arizona Health Care Cost Containment System
- **Sarah Hudson Scholle, Dr.P.H., M.P.H.** – Assistant Vice President for Research and Analysis, National Committee for Quality Assurance (NCQA)
- **Joseph W. Thompson, M.D., M.P.H.** – Director, Arkansas Center for Health Improvement; Surgeon General for the State of Arkansas; Associate Professor in the Colleges of Medicine and Public Health at the University of Arkansas for Medical Sciences; Practicing General Pediatrician at Arkansas Children's Hospital
- **Ken Thorpe, Ph.D., M.A.** – Robert W. Woodruff Professor, Chair of the Department of Health Policy & Management, Rollins School of Public Health of Emory University; Co-directs the Emory Center on Health Outcomes and Quality
- **Paul J. Wallace, M.D.** – Medical Director, Health and Productivity Management Programs; Senior Advisor, The Care Management Institute and Avivia Health, The Permanente Federation

Faculty areas of expertise and/or research include: Chronic Care Management, Medical Homes & Care Coordination, Purchasing and Using the State's Purchasing Power, Policy and Politics of Quality Improvement, Quality Improvement Implementation, Primary Care, Measuring Quality, Payment Reform, Public-Private Partnerships/Engaging Key Stakeholders, Hospitals/Readmissions, Health Disparities, Early Childhood Health, Health Information Technology, Public Reporting/Transparency/Data, and Population Based Health Care/Wellness.

Appendix 2: State Quality Improvement Institute Cyber-seminars

A central feature of the technical assistance component of the SQII is a series of four cyber-seminars, each of which address a distinct quality improvement topic that is of particular concern to the participating states. As of January 2009, three of the four cyber-seminars had occurred, with each event featuring presentations by three faculty experts, followed by a question and answer period. The slides, transcript, and audio recording of each cyber-seminar can be found on the SQII Web site: www.academyhealth.org/state-qi-institute/technicalassistance.htm.

Cyber-seminar 1: Engaging Physicians in Health System Reform

This cyber-seminar gave states a better sense of the importance of engaging physicians in the reorganization of the health care delivery system, identifying the role of physicians in coordinating care, promoting prevention and improving the overall quality of health care, and differentiating between physicians' tasks and those of others in the health care system. The cyber-seminar also explored how purchasing strategies, performance measurement, and reporting can be used as tools for engaging physicians and how physicians may be impacted by the unique realities of individual communities.

Michael Bailit, founder of Bailit Health Purchasing, LLC, detailed his efforts in Pennsylvania as that state works to implement the Chronic Care Model and Medical Homes, and the role of physicians at various levels of that process.

Dr. Charles Willson, clinical professor of Pediatrics at the Brody School of Medicine at East Carolina University and a consultant to the Community Care of North Carolina program, focused his presentation on the process and results of the Community Care program, which works to provide primary care Medical Homes to Medicaid beneficiaries in North Carolina.

Dr. Tom Mahoney, chief executive officer and executive director at the Rochester Individual Practice Association (RIPA), an individual practice association with 3,200 providers, explained how RIPA engaged physicians while implementing a managed care program and the lessons learned from this experience. Among other points, he highlighted the importance of providing clear, actionable, and transparent data, the need to reframe "Quality vs. Cost" measures, and the central role of establishing trust among all parties involved.

Cyber-seminar 2: Using Information to Help Providers Improve: What is the State's Role?

This cyber-seminar gave states a better sense of the role that a state can play in the process of designing a data collection and reporting framework, as well as the potential benefits to a state from partnering with other stakeholders. This cyber-seminar also explored the improvements in the quality of care that can occur when providers collaborate and learn from each other.

Susie Dade, director of quality improvement and administration for the Puget Sound Health Alliance in Washington State, discussed the work of the Health Alliance. She works with others in the community to identify quality improvement opportunities and to stimulate and encourage system and practice changes that will result in improved delivery of care for patients with chronic diseases and increased participation in prevention-related activities.

Dr. Vahé Kazandjian, president of the Maryland-based outcomes research center, The Center for Performance Sciences (CPS) and senior vice president for the Maryland Hospital Association (MHA), discussed his research and policy responsibilities for the Quality Indicator Project, the largest national and international effort to measure and compare indicators of hospital performance. He also spoke more broadly about some of the activities currently underway in Maryland.

Scott Leitz, Minnesota Assistant Commissioner of Health, spoke about Minnesota's new health reform bill that was enacted in May of this year. In his role as assistant commissioner, Scott oversees and directs the department's efforts on health care policy development, and he is spearheading the Pawlenty administration's efforts on health policy and reform.

Cyber-seminar 3: Using Delivery System Redesign & Payment Reform to Reduce Hospital Readmissions

This cyber-seminar gave states a better sense of the varied roles a state can play in the process of reducing hospital readmissions issues through system redesign and payment reform. The cyber-seminar also explored the important role of using data to reduce readmissions and the process of engaging important stakeholders.

Dr. Amy Boutwell, content director at the Institute for Healthcare Improvement (IHI), presented on IHI's work addressing readmissions related issues, and provided some overall context on the issue of preventable hospitalizations and the issue of re-hospitalizations.

Harold Miller, president and CEO of the Network for Regional Healthcare Improvement, director of The Center for Healthcare Quality and Payment Reform, and a Strategic Initiatives consultant for the Pittsburgh Regional Health Initiative, discussed the central role payment reform can play in reducing hospital admissions. Since 2006, Harold has been working on a number of initiatives to improve the quality of health care services and to change the fundamental structure of health care payment systems in order to support improved value.

Kim Streit, vice-president of Healthcare Research and Information for the Florida Hospital Association, detailed the partnership between the Florida Hospital Association and the Florida Department of Health, which demonstrates how states can play a vital role in encouraging the use of data to reduce readmissions.

Appendix 3 - State Quality Improvement Institute State Profiles

SQII Profile - Colorado

State Name: Colorado

Environment

In January 2008, the Colorado Blue Ribbon Commission for Health Care Reform issued a final report to the General Assembly outlining recommendations for comprehensive reform to improve health insurance coverage and manage costs. The Commission recommended an individual insurance purchasing mandate along with initiatives to improve efficiency, connect individuals with appropriate care and coordinate programs. Prior to this, in May 2007, Governor Bill Ritter signed legislation establishing medical homes for children on public insurance in Colorado and mandating a study on the efficacy of the medical home model of care for children. In 2008, the governor created a Center for Improving Value in Health Care (CIVHC). The mandated role of CIVHC is to inventory health care assets in Colorado, identify priorities for improvement, and develop recommendations for funding support and legislative initiatives. CIVHC will be lead by the Colorado Department of Health Care Policy and Financing, in collaboration with the Governor's Office of Policy Initiatives. Important problems identified by the state include deficits in delivery of high quality, accessible health care and significant spending increases in the Medicaid program not paralleled by commensurate quality improvements.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**22**
Access:	**35**
Quality:	**30**
Avoidable Hospital Use and Costs:	**15**
Equity:	**43**
Healthy Lives:	**2**

State Agency Lead for SQII

State of Colorado Department of Health Care Policy and Financing - Joan Henneberry, Executive Director

Final Action Plan Targets

Colorado will focus on getting CIVHC established, staffed, and fully funded by June 2009. CIVHC will bring consumers, business leaders, health care providers, insurance companies, and state agencies together around a common agenda. This group will develop strategic recommendations to identify, implement, and evaluate quality improvement strategies. The CIVHC steering committee has established task forces based on the "It Takes a Region" model for 1) aligning benefits/finances, 2) consumer engagement, 3) transparency/public reporting, and 4) delivery system improvement. Each task force must complete two sustainable QI projects of their selection by June, 2009. The state plans to establish functioning learning network for regional quality improvement efforts throughout the state and coordinate inter-regional communication of health information.

Strategies

Colorado aims to be a leader in national health care reform. This includes chronic care improvement through disease management programs and increasing use of value-based purchasing to leverage the state's purchasing power to drive cost efficiency and quality improvement. Colorado will improve measurement and engagement of providers as a foundation for effective pay for performance tests. Colorado will collaborate with health care providers to identify and implement standardized performance measures and reward providers for meeting targets and achieving improvement. The state is also working toward enhanced use of Medicaid managed care and creation of a statewide medical home concept.

Continued on next page

SQII Profile - Colorado *(Continued)*

Assets

Colorado has numerous reform initiatives, including the Blue Ribbon Commission for Health Care Reform and a "Quality Forum." The Colorado Department of Health Care Policy and Financing (HCPF) convened the Quality Forum with representatives from relevant state agencies, legislators and health care organizations representing consumers, businesses, health care provider organizations. The Forum selected indicators for the SQII with the intent of enhancing programs that have received legislative attention or have improvement initiatives under way. This will augment the momentum and provide leverage for the target improvements. Colorado's Quality Forum will also guide establishment of quality indicators, measures, and improvement goals to form the basis of the new CIVHC.

Challenges

Colorado is concerned with rising medical costs and lack of coordination in its Medicaid program. In Fiscal Year 2006-2007, Colorado Medicaid served 393,077 beneficiaries at a total cost of over $2.06 billion, a 77 percent increase from the year 2000. Colorado identified a subset of high-needs, high-cost beneficiaries who are driving a significant portion of total Medicaid spending. This is an important population to target for care coordination and preventive strategies. This will be carried out in context of Colorado's broader health reform agenda. Although Colorado notes as an asset a number of government programs and non-governmental organizations dedicated to the improvement of quality and cost containment in health care, the state notes the needs for greater coordination of efforts.

Stakeholder Engagement

The new Colorado Center for Improving Value in Health Care is charged with convening a health care quality steering committee consisting of relevant state agencies, health care stakeholder organizations and individuals. The Center's mandate states that major stakeholder groups representing public agencies, plans, providers, and consumers participate, along with representatives of the governor's office. Ongoing initiatives in the state include the Colorado Integrated Care Collaborative, a partnership between the Colorado Department of Health Care Policy and Financing; the Center for Health Care designed to develop models for serving high-needs, high-cost beneficiaries statewide; and the Colorado Clinical Guidelines Collaborative (CCGC) a non-profit coalition of health plans, physicians, hospitals, employers, government agencies, quality improvement organizations, and other entities working to implement systems and processes, using evidence-based clinical guidelines. The state QIO, the Colorado Foundation for Medical Care (CFMC), also offers a variety of interrelated services addressing cost management and quality improvement.

SQII Profile - Kansas

State Name: Kansas

Environment

Reforming Kansas' health care system became a priority policy issue in 2002 under the leadership of Governor Kathleen Sebelius. The Kansas Health Policy Authority (KHPA) was created in 2005 as an independent agency within the executive branch. The KHPA Board established three broad priorities for health reform: 1) promoting personal responsibility – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care; 2) promoting medical homes and paying for prevention – to improve the coordination of health care services, prevent disease before it starts, and contain the rising costs of health care; and 3) providing and protecting affordable health insurance – to help those Kansans most in need gain access to affordable health insurance. Health reform recommendations were delivered to the governor and the legislature on November 1, 2007. Legislation enacted a number of the recommendations in 2008 including a provision that establishes medical homes in the Kansas Medicaid program and State Employee Health Plan.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**20**
Access:	**17**
Quality:	**19**
Avoidable Hospital Use and Costs:	**26**
Equity:	**34**
Healthy Lives:	**27**

State Agency Lead for SQII

Kansas Health Policy Authority (KHPA) - Dr. Marcia Nielsen, Executive Director

Final Action Plan Targets

(1) 85 percent of all children in Kansas will have a medical home by 2012; and
(2) Avoidable hospitalization for pediatric asthma in Kansas will be reduced to no more than 82 per 100,000 for children aged 0 to 17 years by 2012.

Strategies

Kansas ranks 19th on Quality measures and 26th on Avoidable Hospital Use & Costs measures on the Commonwealth Scorecard. With technical assistance from the SQII, Kansas will begin to operationalize the new legislative mandate to include medical homes under Medicaid and the state employee plan. They will develop plans for reforms that link wellness and better care management to improve cost effectiveness in the health care system. As process steps for implementation of medical homes, Kansas will seek stakeholder engagement in defining a medical home in statute and examine purchasing strategies that provide payment incentives for coordinated care and wellness.

Assets

KHPA is charged with developing a statewide health policy agenda to include the efficient purchase of health care services, the promotion of public health oriented strategies, and data driven health policy to coordinate health and health care for Kansas. The KHPA is required by statute to adopt health indicators and include baseline and trend data on health costs and indicators in each annual report to the legislature. A Kansas Consumer Health Care Cost and Quality Transparency Project (Kansas Health Online, www.kansashealthonline.org) is currently underway to collect and make available existing health and health care data resources to the Kansas consumer. By 2010 Kansas will implement medical home incentive payments/contractual rate adjustments in the state employee and Medicaid programs, and will continuously evaluate the impact of the changes.

Challenges

The state faces political and budget challenges to enhancing Medicaid payments associated with medical homes. While the state legislature recently passed development of medical home model there is no immediate plan to increase reimbursement or payment methodology for Medicaid providers.

Stakeholder Engagement

Kansas Medical Society and Kansas Hospital Association are developing a model similar to the "Iowa Quality Collaborative." The initiative has the potential to facilitate widespread adoption of the medical home model by providers and could serve as a valuable means to engage consumers and providers in the development and implementation of the medical home concept.

SQII Profile - Massachusetts

State Name: Massachusetts

Environment

In 2006, Massachusetts enacted universal coverage legislation that required individuals with access to affordable coverage to obtain or purchase it. The law provided for expanded Medicaid eligibility, government subsidies, and insurance market reform to ensure affordability. The state reports that 72,000 individuals have enrolled in Medicaid/SCHIP, 191,000 have purchased private insurance, either on their own or through their employers, and that 176,000 have enrolled in the state's subsidized plan. As of March 31, 2008, the number of Massachusetts residents enrolled in health insurance increased by more than 439,000. Since reform was enacted, the state has engaged in planning efforts to improve quality of care, improve the health of the population and leverage information and purchasing powers to improve value. Massachusetts identified improved coordination of care as an important strategy for improving quality, reducing disparities, and avoiding unneeded hospital costs. In August 2008, Massachusetts enacted S. 2863 as a cost containment, efficiency and transparency component to the reform initiative. Massachusetts continues to focus on system improvements initiatives including: 1) adoption of consistent payment policies for serious reportable events; 2) coordination and alignment of performance measures and incentives; 3) payment methodology reform; 4) disease management and wellness initiatives (with an initial focus on diabetes); and 5) administrative simplification.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**8**
Access:	**2**
Quality:	**3**
Avoidable Hospital Use and Costs:	**35**
Equity:	**1**
Healthy Lives:	**20**

State Agency Lead for SQII

Executive Office of Health and Human Services - Dr. JudyAnn Bigby, Secretary

Final Action Plan Targets

Goal 1: Residents of Massachusetts will live in communities that support healthy lifestyles for the prevention and management of chronic conditions.

Goal 2: Primary care providers in Massachusetts will provide high quality chronic illness care characterized by productive interactions between practice team and patients that consistently provide the assessments, support for self-management, optimization of therapy, and follow-up.

Goal 3: Massachusetts acute care hospitals will improve the quality of transitions of care (hospital discharge) to reduce hospital re-admissions. Improve the care of patients with chronic illness while in the hospital.

Goal 4: Massachusetts residents with a chronic disease will have a clear understanding of their condition, develop self-management skills, and will assume a shared responsibility for their condition with their healthcare provider.

Goal 5: Reform payment policies and align measurements with the priorities and goals of the SQI plan.

Goal 6: The Commonwealth will have a Chronic Care Information System that supports statewide implementation of the Blueprint for both individual and population-based care management.

Continued on next page

SQII Profile - Massachusetts *(Continued)*

Strategies

Massachusetts's work with the SQII is aligned with broader efforts to improve health care quality. The state has proposed to first use marker diseases/conditions and then expand from the pilot test stage to statewide adoption. Massachusetts will be working to build an accountable healthcare system. The system should focus on the patient by optimizing services and payment to maximize health outcomes and address the multiple and complex determinants of health and health care. The state created an umbrella initiative, *HealthyMass,* to provide the structure for strategy development, project coordination, and plan implementation. The organizing framework for the SQII Action Plan relies on elements of the Chronic Care Model and the Medical Home. The Commonwealth of Massachusetts will pursue a multi-faceted approach that includes improvements in clinical care, public health, and health policy (payment for, organization of, and delivery of services). The state will engage stakeholders to create a critical mass for innovation and will build public and private partnerships and collaborations necessary to effect change.

Assets

Massachusetts has multiple programs and entities in place to address common goals and implementation of the health reform activities. The state has a legislatively established Health Care Quality and Cost Council, a Medicaid pay-for-performance program, and a Health Disparities Council. The mission of the Health Care Quality and Cost Council is to develop and coordinate the implementation of statewide health care quality improvement goals that lower or contain the growth in health care costs while improving quality of care, including reductions in racial and ethnic health disparities.

Challenges

The state has noted its low rankings in measures related to cost management and coordination of care for hospitalized patients. Under the "Avoidable Hospital Use and Costs," Massachusetts was ranked 48th in the nation for the total single premium per enrolled employee at private-sector establishments that offer health insurance. The rate of increase in health insurance premiums in Massachusetts is significantly higher than the national average (13 percent in the state from 2005-2007 compared to 6 percent nationally) and outpaces general inflation rates and wage increases. Massachusetts notes the interrelated nature of many of the measures, where preventive opportunities missed are an underlying factor in higher rates of re-hospitalization and overall costs.

Stakeholder Engagement

In a unique strategy to align state health promotion and purchasing efforts, the state engaged nine diverse state entities as signers of a memorandum of agreement entitled the *Healthy Massachusetts Compact*. These goals were adopted with input and advice from its Advisory Committee, which includes representation from consumers, business, labor, health care providers, and health plans. The SQII team, Department of Public Health, agencies signed on to the Healthy Massachusetts Compact, Massachusetts Medical Society, the Massachusetts Hospital Association, and others are participating in the strategy implementation for HealthyMass and other reform work.

SQII Profile - Minnesota

State Name: Minnesota

Environment

Minnesota has a history of experimentation in cost and quality innovations, including the SmartBuy Alliance, the Buyers Health Care Action Group, and other initiatives to promote optimal care. In 2008, Minnesota enacted comprehensive health care reform legislation. The reforms adopt recommendations of Governor Tim Pawlenty's Transformation Task Force and the Legislature's Health Care Access Commission. The legislation creates a comprehensive health care package that addresses the following areas: public health, health care affordability, chronic care management, payment reform, cost and quality transparency, administrative efficiency and health care cost containment. Information about the reform can be found at: www.health.state.mn.us/divs/opa/08reformsummary.html. Minnesota has been a leader in provider measurement and information transparency. By deploying community assets to develop evidence-based practice standards and performance measures, Minnesota has engaged support of physicians in continuous process improvement. Payers and plans have used both financing and data transparency to direct patients to higher performing providers and reward the providers for high quality care. The current reform initiative builds on and expands the state's work in transparency of information, innovative reimbursement/payment methods, and continuous improvement in care management.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**11**
Access:	**9**
Quality:	**12**
Avoidable Hospital Use and Costs:	**10**
Equity:	**38**
Healthy Lives:	**7**

State Agency Lead for SQII

Governor's Health Cabinet and Commission of Human Services – Cal Ludeman, Commissioner of Human Services, Minnesota Department of Employee Relations and Chair, Governor's Health Cabinet

Final Action Plan Targets

Minnesota's action plan addresses the need for technical assistance to integrate elements of the reform bill, build on the state's infrastructure and successes, and create measurable improvements. Goals are to reduce rate of cost increase, improve population health, and improve patient experience.

Strategies

The state action plan is consistent with the state's efforts to implement the comprehensive reform legislation. Minnesota will address purchasing, care improvement, and transparency through:

- The development of standardized sets of measures by which to assess the quality of health care services;
- The development of a system of quality incentives, under which providers are eligible for quality-based payments that are in addition to existing payment levels;
- The development of a peer grouping system for providers based on a combined measure that incorporates both Provider risk-adjusted cost of care and quality of care;
- The development of definitions of baskets of care; and
- The publication of results from the peer grouping initiative.

Continued on next page

SQII Profile - Minnesota *(Continued)*

Assets

Minnesota has achieved relatively high quality at costs that are relatively low compared to other states. The state has a history of collaboration between private sector providers, health plans and the public sector. State assets for measurement include the Institute for Clinical Systems Improvement (ICSI) and Minnesota Community Measurement (MNCM). The Buyers Health Care Action Group (BHCAG) is an employer purchasing coalition working toward value-based purchasing, transparency of information, consumer engagement, and quality-based competition among providers. The "Smart Buy Alliance" was created in 2004 as a unique public-private partnership of health care purchasers. The goal of the Smart Buy Alliance is to streamline health care purchasing to make the health care system more efficient and accountable. Members of the Alliance represent government purchasers, large employers, small employers, and labor unions representing over 60 percent of state residents. One goal of the Alliance is to adopt uniform methods of measuring quality of care and results and to purchase health care based on those measurements.

Challenges

Minnesota's experimentation with value based purchasing has demonstrated some of the reverse incentives incorporated in the financing system. The state notes that in model chronic care management programs at two hospital systems reduced readmissions due to better care. This resulted in lost revenue to the hospitals. The state is committed to payment reform that would eliminate the "success paradox" that penalizes providers for improvement in patient's health.

Stakeholder Engagement

The state has a long history of collaboration on purchasing, care improvement and transparency. Stakeholders are involved in many of the community assets and organizations identified above. In addition, Minnesota has both a Governor's Health Care Transformation Task Force and the Legislative Commission on Health Care Access. Stakeholders include purchasers, providers, consumers and organizations representing evidence-based practice such as ICSI and MNCM.

SQII Profile - New Mexico

State Name: New Mexico

Environment

New Mexico is a rural state with significant challenges in access to care. State leaders have recognized that the key to successful quality improvement is reducing the vast variation in access to care, particularly in rural communities. Governor Bill Richardson introduced health care reform legislation that would expand coverage and consolidate public health funding programs to improve efficiency and increase use of electronic health records. The governor has also identified a number of public health priorities– childhood vaccination levels, teen pregnancy rates, obesity, and hospital care in the state strategic plan. Ultimately the State has identified a need to re-orient the system towards health promotion and disease prevention to reduce health disparities and improve health.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**35**
Access:	**50**
Quality:	**41**
Avoidable Hospital Use and Costs:	**5**
Equity:	**41**
Healthy Lives:	**14**

State Agency Lead for SQII

Robert Wood Johnson Foundation Center, University of New Mexico - Robert O. Valdez, Executive Director

Final Action Plan Targets

New Mexico will use Year 1 to focus on building a coalition to support health care quality improvement. After the stakeholder engagement phase the state will turn to a long-term agenda of performance measurement, standard setting, and interventions.

Strategies

The project will engage in regular analysis of the various data systems available in New Mexico to assess progress and identify areas of opportunity. The RWJF Center will engage a coalition of state and local government officials, health services researchers, and private and public health care providers to:

1) Develop the information necessary for the quality improvement process;
2) Analyze county-level population characteristics, care delivery system characteristics, and performance;
3) Identify federal, state, local, and organizational policies that affect system performance or impede individuals/families from engaging in desired behaviors;
4) Identify care delivery practices amenable to improvement; and
5) Identify opportunities to improve system performance or support individual/families to engage in desired behaviors.

The state has indicated it will address local quality improvement efforts aligned with its diverse population groups. New Mexico anticipates the need for state-level health policy that addresses the social, cultural, geographic, linguistic, and economic factors that affect health care in these communities that require change or modification as well as system delivery changes or enhancements.

Assets

The state has opportunity to leverage its purchasing power due to the high proportion of individuals (particularly children) in New Mexico covered by Medicaid, SCHIP or state-funded public assistance programs. New Mexico has a number of targeted initiatives in place, including a Clinical Prevention Initiative, New Mexico Immunization Coalition, New Mexico Takes on Diabetes, and Medicare hospital quality reviews.

Challenges

Although New Mexico is committed to transparency of data, state leaders note that, in the context of under-service and provider shortages, it is challenging to implement the concepts of using performance data to guide physician/hospital selection in rural areas. In addition, New Mexico's high uninsurance rate makes it difficult to change provider behavior through payment reform strategies.

Stakeholder Engagement

The New Mexico Quality Improvement Institute steering committee proposed to convene a larger body of stakeholders including state and government officials in the Health and Human Services departments and representatives of a variety of medical, dental, private and public health provider communities.

SQII Profile - Ohio

State Name: Ohio

Environment

Governor Ted Strickland has announced an interest in health care reform that would include quality improvement. The state focuses its planning and development efforts in three areas: Creation of the Office of Healthy Ohio; Participation in the State Coverage Institute; and Creation of the Health Information Partnership Advisory Board. Since 2007, directors of state agencies and other state entities that relate to health and health care have been convening in a series of facilitated sessions to develop a vision for a Healthy Ohio.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**24**
Access:	**15**
Quality:	**23**
Avoidable Hospital Use and Costs:	**37**
Equity:	**14**
Healthy Lives:	**41**

State Agency Lead for SQII

Office of Governor Ted Strickland - Amy Rohling McGee, Executive Assistant for Health and Human Services Policy

Final Action Plan Targets

The SQII Team will implement a strategy to coalesce diverse group of stakeholders around a portfolio of strategies that would underpin systematic reform. Ohio will convene stakeholders to solicit input on approaches for the state that would:

1) Offer opportunities for short and long term return on investment (quantified in both human and monetary terms);
2) Be actionable by a wide array of stakeholders (state government, insurers, employers/purchasers, providers, consumers); and
3) Be informed by a variety of local initiatives that are ongoing throughout the state.

Strategies

The Ohio Quality Improvement Institute Team executated a Ohio Health Quality Improvement Summit in November 2008. The calling question for this statewide Summit was: "What are the top 10 strategies that will transform Ohio's health care system into a high quality, cost-effective, high performing system that optimizes the health of Ohioans by 2013?" The state developed a report from the meeting and will be using its multi-stakeholder group to identify high impact interventions.

Assets

The Office of Healthy Ohio, created in 2007, addresses health promotion, disease prevention, and health equity through the enhancement of existing programs, improved coordination across agencies and organizations, and increased accountability. Ohio participates in the Robert Wood Johnson Foundation (RWJF)/AcademyHealth "State Coverage Institute" to develop reforms to provide affordable coverage to Ohio's uninsured residents. The effort is supported by a 40-person Health Care Reform Advisory Group which includes representatives of all the key stakeholders, including consumer advocates, hospitals, doctors, insurers, large and small employers, free clinics, community health centers, and state and local officials. Ohio also has a number of private sector initiatives, including participation of two communities in the RWJF "Aligning Forces for Quality" program and two communities that are participating in "Bridges to Excellence." In addition, the Ohio Business Roundtable has chosen the health care system as a focus; they are investing staff and resources in constructively participating in the process of health reform in Ohio.

Challenges

Ohio has multiple initiatives in place and observes a need to coordinate and engage stakeholders and set priorities.

Stakeholder Engagement

The Ohio SQII Plan will build on the organizations that represent public and private sector delivery systems and purchasing agencies. Ohio will engage existing groups as necessary, including the Health Care Coverage Reform Advisory Team, the Healthy Ohio Advisory Team and the Health Information Partnership Advisory Board. Ohio also plans to engage legislators and other stakeholders at key points in the process.

SQII Profile - Oregon

State Name: Oregon

Environment

Oregon has a long history of health care reform enacted in the Oregon Health Plan. Oregon has focused on driving value through the prioritized list of health services developed with ongoing community input, along with value-based purchasing initiatives in both the public and private sectors. Value purchasing strategies highlighted by the state include reliance on managed care, evidence-based drug reviews, and pharmacy bulk-purchasing pool in collaboration with Washington State. In 2007, Oregon enacted the Healthy Oregon Act, the state's latest health reform planning legislation. The law creates the Oregon Health Fund Board, provides a stable policy structure, and calls for a comprehensive reform plan to be presented to the Governor by October 1, 2008. Prior to the legislation, Oregon issued a "Roadmap for Health Care Reform," which outlines a vision and a framework Oregon can use to move the health care system forward. The Roadmap calls for reforms based on public/private collaboration for value-based purchasing and transparency, adoption of electronic health records, improvements in safety, establishment of medical homes, and support for innovations that promote cost-effective high quality care. The Healthy Oregon Act will be a centerpiece for quality efforts in Oregon. The Office for Oregon Health Policy and Research (OHPR), in partnership with the Oregon Health Policy Commission (OHPC) and the Insurance Division, has initiated transparency efforts in the state with public reporting of hospital cost and quality data and increased system interoperability as goals.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**34**
Access:	**45**
Quality:	**36**
Avoidable Hospital Use and Costs:	**2**
Equity:	**48**
Healthy Lives:	**19**

State Agency Lead for SQII

Oregon Health Policy Commission – Gretchen Morley, Director

Final Action Plan Targets

1. Percent of children ages 19 to 35 months who received all recommended doses of five key vaccines. (Oregon ranks 49th for this measure, with a state percentage of 72.9.)
2. Percent of children with a medical home. (Oregon ranks 34th in this measure, with a state percentage of 43.4. The best rate is 61 percent and the median is 47.6 percent.)
3. Percent of Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them. (Oregon ranks 38th in this measure with a state percentage of 67.7. The best rate is 74.9 percent and the median for all states is 68.7 percent.)

Continued on next page

SQII Profile - Oregon *(Continued)*

Strategies

Measurement issues are key to the state's approach. Oregon intends to initiate SQII activities by evaluating current measurement and reporting systems. Oregon has noted that a portion of its performance variation and ranking results is attributed to pockets of under service, and that addressing the needs of these communities may reduce disparities as well as promote systems improvement. The state will promote partnerships to enhance ongoing systems of care, targeted according to state trends data.

Strategy 1: Increase availability, reporting, and use of comparable and systematic cost and quality data;
Strategy 2: Identify and reward innovative efforts to create high-performing delivery systems that produce optimal long term value; and
Strategy 3: Identify and reward innovative efforts to create healthy communities that support healthy choices.

Assets

The Office for Oregon Health Policy and Research is the lead health policy advisor to the governor's office and the legislature. OHPR has specific statutory responsibility to monitor cost and performance of health facilities in Oregon. The Oregon Health Policy Commission has responsibility for developing and monitoring the state health policy and advising the administrator of OHPR, the governor and the legislature; the Commission has specific statutory authority to develop a central repository of health data related to cost and quality as well. In addition, the Oregon Public Employees Benefit Board (PEBB) is a national leader in its value-based purchasing efforts. The Division of Medical Assistance Programs (DMAP), Oregon's Medicaid agency, seeks to drive higher levels of clinical quality performance and improved quality of health care for Oregon Health Plan clients through a combination of efforts including performance measurement, evidence-based care and public reporting. The Oregon Health Care Quality Corporation (QCorp), a multi-stakeholder non-profit organization made up of health plans, physician groups, hospitals, public and private purchasers and consumers, is lead on an Aligning Forces for Quality grant from the Robert Wood Johnson Foundation. The group has provided leadership in developing common measures of ambulatory care and the strategic plan for market-driven change. Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization. In addition, a number of health plans in Oregon, including the largest Medicaid managed care plan, CareOregon, are currently piloting medical home models. Lessons and best practices from these pilots can help other managed care plans determine how medical home services can most effectively and efficiently be delivered to Oregon's children.

Challenges

Like other states, Oregon faces the challenge of coordinating multiple initiatives that exist throughout the state.

Stakeholder Engagement

Stakeholders are engaged in planning and review of the state's multiple reform programs and reports. OHPR has established a SQII Work Group made up of key stakeholders in Oregon's quality arena representing purchasers, providers, advocates, and health plans. Along with the governor's office, the Office for Oregon Health Policy and Research, the Health Policy Commission and the Oregon Health Fund Board, the Institute team includes bi-partisan legislative leadership, PEBB, DMAP, the state public health agency, the Insurance Division, the Patient Safety Commission and QCorp.

SQII Profile - Vermont

State Name: Vermont

Environment

Vermont is enacting a variety of reforms under its "Blueprint for Health," a health care improvement initiative. The Blueprint model calls for pilot testing of innovations in "Blueprint Communities" with subsequent roll out statewide. The Blueprint is codified in statute as the state's plan for transforming health care delivery through systems-reform based on public-private partnerships. The state is creating a sustainable infrastructure with a priority on improved information exchange to facilitate coordination and care delivery. Vermont is pilot testing initiatives on medical home development and information exchange. The Blueprint implementation is guided by an Executive Committee representing stakeholder perspectives. The 2007 legislative session created new Medical Home Pilot projects, and defined insurer participation in the medical home pilots.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**3**
Access:	**8**
Quality:	**8**
Avoidable Hospital Use and Costs:	**11**
Equity:	**3**
Healthy Lives:	**14**

State Agency Lead for SQII

Office of the Secretary of Administration – Craig Jones, Director, Blueprint for Health

Final Action Plan Targets

1. Percent of adults age 50 and older received recommended screening and preventive care
2. Percent of adult diabetics received recommended preventive care
3. Percent of asthmatics with an emergency room or urgent care visit in the past year

Strategies

Beginning in July 2008, Vermont will pilot test the Blueprint integrated medical home model in 3 communities. The Vermont team is charged with implementing this project linking it to other health initiatives in the state, and monitoring its success. Vermont will also identify strategies to enhance the likelihood that the integrated pilot model will be sustainable. The state will use the following strategies:

- Use HEDIS measures to set goals and evaluate quality in the integrated pilot practices.
- Use CAHP survey measures to set goals and evaluate patient experience in the integrated pilot practices.
- Consider expanded use of surveys to evaluate patient self-management capacity.
- Add elements to clinical planning templates that emphasize goals with a high likelihood of helping control health care costs.
- Complete the financial model that evaluates the potential return-on-investment association with the Blueprint integrated health and prevention design.
- Work with Vermont Medicaid to plan collaborative chart review process.
- Work with NCQA regarding a scoring methodology.
- Consider Arkansas approach to community activation.
- Make sure that a core set of data elements guides the development of the exchange. Guard against piecemeal transmission that leads to data that can't be used across organizations.
- Consider strategies for statewide health risk assessment process that can be used for strategic planning and evaluation of health care delivery and prevention

Continued on next page

SQII Profile - Vermont *(Continued)*

Assets

Beginning in 2005, Vermont has used the Blueprint and state funds in a number of initiatives: provider training and incentives, expanded use of information technology, evidence based process improvement, clinical microsystems training, and self management workshops. The state offers support for community activation and prevention programs statewide. Through the Blueprint, Vermont has developed a statewide "self management network" of regional coordinators and trained leaders. Commercial insurers in Vermont and Medicaid are collaborating on a multi-payer claims-based evaluation of the health and economic impact of the Blueprint medical home pilots as compared to routine care and traditional disease management programs. The collaboration establishes an infrastructure for evaluation using administrative data sources (e.g., annual health maintenance visit, screening and diagnostic procedures, labs, prescribed medications), and the ability to compare Blueprint medical home pilot communities, other Blueprint communities, and non-Blueprint communities. The Blueprint team will work closely with the Quality Improvement Institute to assure that the criteria used to measure the three selected indicators are measurable, clinically meaningful, and nationally relevant.

Challenges

While Vermont ranks in the top quartile of states on the 2007 Commonwealth Fund State Scorecard on Health System Performance, the state recognizes the need for and opportunity for improvement.

Stakeholder Engagement

Vermont has demonstrated a sustained statutory and financial commitment to improved quality and health care reform, which in part is attributed to engagement of stakeholders in the planning and implementation process. The state includes diverse perspectives (including state legislators) in the Healthcare Reform Commission and on the Blueprint Executive Committee. Blueprint leadership includes all major stakeholders (as called for in statute) including: the Governor's Office, the Legislature, Medicaid, commercial payers, hospitals, providers, and others.

SQII Profile - Washington

State Name: Washington

Environment

In 2005, Governor Chris Gregoire launched a five point strategy for health care reform: (1) evidence based care, (2) promote prevention, healthy lifestyles and healthy choices, (3) better manage chronic care, (4) create transparency, and (5) better use information technology. Comprehensive legislation was enacted in 2007 based on these principles at the recommendation of a Washington Blue Ribbon Commission on Health Care Costs and Access (BRC). Washington's legislation provides for insurance coverage of all Washington children by 2010 and links children to a medical home. The 2007 legislation also directs the state to use purchasing power to improve quality and directs the Medicaid agency to take action in promoting patient-centered medical homes to beneficiaries. The state has multiple initiatives designed to promote coordinated care consistent with the "Chronic Care Model" (developed in the state) and to align reimbursement and resources to promote the model. Washington has implemented a "learning collaborative" to encourage expansion of primary care practice capability to reflect the comprehensive "medical home" concept. The concept will align care delivery capabilities with reimbursement strategies and provider performance measures. Washington's vision includes implementation of practice level information systems and data management strategies to enable ongoing measurement, improvement, and rewards related to performance.

2007 Commonwealth Fund State Scorecard Ranking

Overall Rank:	**17**
Access:	**27**
Quality:	**34**
Avoidable Hospital Use and Costs:	**6**
Equity:	**37**
Healthy Lives:	**13**

State Agency Lead for SQII

Department of Social and Health Services - Health and Recovery Services Administration – MaryAnne Lindeblad, Director, Division of Healthcare Services, Department of Social and Health Services (DSHS)

Final Action Plan Targets

For the SQII, Washington is working to define and improve access to medical homes, develop reimbursement approaches to incentivize improved care, and engage consumers and providers in participating in patient-centered medical homes.

Continued on next page

SQII Profile - Washington *(Continued)*

For the SQII, Washington's action plan identifies specific steps and timeframes to:

1. Create an operational definition of medical home in order to measure and improve medical home capacity in Washington;
2. Develop reimbursement strategies to support providers in adopting a medical home model of patient-centered care; and
3. Engage consumers and providers in participating in patient-centered medical homes through information transparency and use of "navigators" to assist patients.

Assets

The state considers its health care reform activities for the past decade to have been an incremental approach to increase access and contain costs through contracting and reimbursement strategies. The state is expanding that scope to address quality of care. Washington has developed the Washington State Collaborative to Improve Health as a mechanism to define and implement patient centered medical homes. Other assets include the Puget Sound Health Alliance (the Alliance), a well-established regional partnership of employers, physicians, hospitals, patients, and health plans working together to improve quality and efficiency while reducing the rate of health care cost increases. The state has established a Children's Healthcare Workgroup to develop payment and care coordination strategies to implement the medical home directive from the legislature. Washington will establish a Quality Forum to serve as a venue for promoting information to consumers and providers on best practices, quality data, and evidence based medicine. Washington is pilot testing medical home models in anticipation of expansion through reform and other initiatives.

Challenges

Washington recognizes the "challenge" of coordinating a wealth of programs and organizations involved in systems improvement. The state has embraced accountability for organizing and engaging public and private stakeholders.

Stakeholder Engagement

State agencies will be engaged in reform under the governor-designated leadership of DSHS. The state's reform legislation and BRC are built on the platform of engaging patients and providers more fully. Participants include the Children's Healthcare Workgroup, Washington State Collaborative to Improve Health, Medical Home Workgroup, Puget Sound Health Alliance, and a state "Quality Forum" technical advisory committee. The Group Health Cooperative is also committed to participating in testing and implementation of the program.

Appendix 4: State-Reported Policy Levers and Approaches

Strategies Proposed By States for Health Care Reform
These reflect some of the proposed approaches taken by states in health care reform initiative. These topic areas are reflected in technical assistance provided to states

Chronic Disease Management/Medical Homes

- Aggressive case management, education and care coordination
- Focus on care of high-cost Medicaid patients provided through Medicaid contractors/plans
- Create medical home/primary care home
- Establish clinical guidelines for care of chronic conditions
- Legislatively-mandate definition of Medical Home with outcome measures
- Change payment policies to encourage medical homes/primary care (payment add-ons)
- Measure avoidable hospital costs
- Medical Homes pilots that include:
  - financial reform;
  - advanced clinical tracking;
  - evidence based practice improvement;
  - local Community Care Teams (CCTs) that provide an infrastructure for primary provider coordinated care support, self management, and prevention;
  - integration with broader community prevention efforts; and
  - systematic program evaluation at state and practice levels.

Population Health/Wellness

- Wellness initiative for state employees (health assessment, health coaches)
- Partnerships with businesses, schools and others to ensure wellness and chronic disease prevention
- Work with communities to promote healthy environments
- Public education/awareness campaigns
- Overall prevention focus
- Interagency survey to determine all the state health initiatives that relate to prevention
- Create wellness and prevention infrastructure in health care communities statewide

Disparities Reduction/Consumer Engagement

- Web-based portal for health consumers
- Community Health Record that gives physicians access to claims information and e-prescribing
- Use of personal, consumer-controlled electronic health records
- Use of Patient Navigators to assist in care coordination
- Medical homes/care coordination initiatives

Continued on next page

Information Integration/Public Reporting

- Build a statewide health information exchange network
- Stakeholder group works to develop public reporting measures
- Establish a multi-payer claims-based collaboration for evaluation of the health and cost impact of reform
- Public-private collaboration on value-based purchasing, managing for quality and transparency
- HIT Advisory Board with key stakeholder groups
- Increase use of HEDIS measures or NCQA recognition in public and private programs
- Physician engagement in measure development and reporting

Payment Reform

- Coordinate purchasing and contracting across payers
- Adopt or pilot pay-for-performance with explicit payment for quality
- Use payment systems to encourage care in the most cost-effective setting
- Revise payment policies for payment of serious, reportable events
- Tiered provider networks: establishing one to three levels for providers to encourage them to coordinate care and ultimately take responsibility for the total cost of care
- Provide financial incentives to consumers to choose quality primary care providers. Enable patients to compare providers on cost and quality
- Simplify and standardize payments to providers across payers
- Establish community-wide “baskets” of care
- Use contracts to incentivize improved electronic communication, reduced medical errors, and prevention
- Share costs for local multidisciplinary community care teams across payers
- Reduce administrative costs through technology and shared standards across public and private payers
- Reduce provider-driven demand by aligning community needs with the development of new facilities, treatments, etc.

Cost Reduction

- Improve chronic care management in outpatient settings using strategies such as medical home and care coordination
- Analyze root cause of re-hospitalization and avoidable hospitalization
- Reduce unwarranted variations in service utilization through analysis, practice improvement