How States Can Be Successful In Leading Health Care Delivery System Reform

Shelly Ten Napel, M.S.W., M.P.P., Enrique Martinez-Vidal, M.P.P., Alison Rein, M.S., and Hilary Kennedy, M.P.A., M.Sc.

November 2011

www.academyhealth.org

AcademyHealth

Introduction

Over the past year, health reform has moved largely into the purview of states. A recent multi-state technical assistance project designed to help states improve quality and value in their health care system can provide several valuable lessons for state policymakers and those working to help states be successful. The project offers valuable insights into: what factors are predictors of state success, what barriers states are likely to encounter, and what technical assistance strategies can help a state achieve its health reform goals.

From 2008-2010, AcademyHealth, with support from The Commonwealth Fund, coordinated the State Quality Improvement Institute (SQII), a project designed to advise and accelerate state quality improvement efforts. An examination of the experience of eight states (Colorado, Kansas, Massachusetts, Minnesota, Ohio, Oregon, Vermont, and Washington[1]) that completed the more than two-year project provides insights into elements that can make reform efforts successful at the state level, as well as the types of barriers that can prevent progress. All of the states participating in the SQII were pursuing the same overall objective: achieving better value in their health care systems (i.e., higher quality health care at a lower cost). Nevertheless, they varied in their approaches and accomplishments. This brief draws some conclusions about those differences, and provides some "lessons learned" for technical assistance providers and others who seek to help make state reform efforts successful.

Understanding the potential of technical assistance to states is even more critical given the enactment of the Patient Protection and Affordable Care Act (ACA). Capitalizing on the opportunities available under the ACA for delivery and payment systems redesign will be critical to sustain the coverage expansions included in the new federal law.

State	Principal Quality Improvement Initiatives Supported by Technical Assistance from the SQII*
Colorado	The early implementation of the Center for Improving Value in Health Care (CIVHC)
	Development of a Colorado-based All-Payer Claims Database
Kansas	Medical home pilot
	Medicaid cost containment
Massachusetts	Patient-Centered Medical Home Initiative
	Massachusetts Strategic Plan to Reduce Readmissions and Improve Transitions of Care
Minnesota	Provider Peer Grouping
	Baskets of Care
	Early discussions around the implementation of Accountable Care Organizations
Ohio	Establishment of the Health Care Coverage and Quality Council
	Support for the Medical Homes and Payment Reform Task Forces
Oregon	Providing expertise to the Health Systems Performance Committee of the Oregon Health Policy Board
	Technical resources for the development of an Oregon-based All-Payer Claims Database
	Patient-Centered Primary Care Advisory Group
Washington	Washington Patient-Centered Medical Home Collaborative
	Multipayer Reimbursement Model Pilot
Vermont	Ongoing technical support for the refinement and expansion of the Blueprint for Health

*Note: In some cases, states had already passed legislation enacting the initiatives described above before the SQII began (i.e., Minnesota, Vermont, and Oregon). In those cases, SQII supported the challenging work of policy refinement and implementation.

Methods

Data for this brief were collected through exit interviews with the team leaders of the eight participating states. Additional information was collected through observation, written reports and action plans from the states, and presentations by state officials and expert faculty. The authors continuously communicated with representatives of all eight states throughout the course of the SQII initiative.

States Identify Similar Delivery System Reform Goals

After a selection and site visit process, the SQII convened all participating states for an intensive two-and-a-half day training and goal-setting meeting. States brought teams of both public and private sector leaders. Some states, like Vermont and Minnesota, came to the meeting with fairly established goals that were already enumerated in legislation. Other states

revised and adapted their goals during the course of the meeting, as they learned from both expert faculty and each other. As all eight states identified their goals, they began to coalesce around several strategies, including:

- Patient-centered medical homes;
- Improved transitions of care and reduced preventable hospital admissions and readmissions;
- Cost and quality measurement efforts;
- Multi-payer approaches to payment reform;
- Improving population health and achievement of the Triple Aim;[2] and
- Cross-cutting consumer engagement strategies.

In addition to those strategies, a few of the states grew increasingly interested in the concept of accountable care organizations (ACOs), reflecting the burgeoning interest in the topic nationally.

Although there were important variations in the reform strategies and methods employed by participating state teams, they all wanted to improve prevention and chronic condition management efforts, with particular emphasis on improving care coordination.

In spite of having selected very similar goals, the eight SQII states varied in their approaches and accomplishments for several reasons. First, each state was building on a different foundation of strengths and limitations. Second, the role and engagement of stakeholders varied significantly between states. Third, political leadership was stronger and/or more continuous in some states than others; and fourth, states invested differentially in key information infrastructure components (e.g., data collection tools and analysis). Finally, states exhibited varying levels of commitment (and enjoyed differing levels of cooperation) in leading multi-payer payment reform that would provide the kind of long-term transformation necessary to achieve the stated objective of high-value health care.

States Build on Existing Strengths

By the close of the SQII (December 2010), Vermont had the most well-funded and fully executed delivery system reform strategy in place. The Blueprint for Health model—which enables providers to offer a full complement of medical home services with the help of community-based care teams—was piloted in three communities during 2008 and 2009 with legislation passing in 2010 to expand the model statewide. Vermont's success was built on years of experimentation with chronic condition management using the Chronic Care Model.[3] By the end of the SQII, the Vermont legislature was considering how to incorporate the ACO concept, which would build on the Blueprint model and expand it beyond primary care.

Craig Jones, the Vermont SQII team leader and director of the Blueprint, notes, "We have gone from a stage of 'this doesn't work,' to 'this will work; we can make it work.'" His point is that—with persistent leadership and consistent progress—success breeds success.

When Minnesota joined the SQII, it already had a longstanding culture of collaboration, in which the state worked closely with purchasers and plans to begin developing standard cost and quality measures.[4] In 2008, that significant groundwork enabled the state to pass legislation that includes, among other components:

- *Provider peer grouping*: The legislation required the development of a provider tiering system based on their performance on cost and quality metrics.
- *Baskets of care*: The legislation charged the Department of Health with choosing several conditions that would allow bundled payments across providers for a certain medical procedure or condition; for example, knee surgery. The state, in coordination with the private sector, would set quality metrics and providers would bid the expected cost for a basket of care.
- *Medical homes*: The state and the private sector were charged with establishing a set of agreed-upon metrics for a Minnesota health care home. The state and the private sector would then be required to pay an increased amount to providers who met the standard. The statewide standards are based on outcome rather than process measures.[5]

Although Ohio and Colorado had many successful private sector initiatives, there was less of a history of state action. In 2006, voters in both states elected new governors who were committed to improving health care quality. Each state decided to establish a public-private quality council—the Ohio Health Care Coverage and Quality Council and the Colorado Center for Increasing Value in Health Care (CIVHC)[6] — to vet ideas and identify priorities for the state. Although each of these initiatives will likely provide valuable infrastructure for the state moving forward, the two states spent much of the SQII program establishing relationships and building the infrastructure to support and spur eventual reforms. That groundwork was not necessary in states like Minnesota and Vermont, which both had a history of collaboration between the public and private sector and an understanding that the state would assume a leadership role.

States with Supportive Stakeholders are More Likely to Have Successful Quality Improvement Initiatives

Representatives of both Massachusetts and Minnesota noted that it was critical to have insurers be supportive of their delivery system reform efforts.[7] Vermont has a Blue Cross/Blue Shield plan that has been proactive and willing to work with the state toward reform. In general, states in the SQII that have mostly local and nonprofit health plans have had an

easier time promoting their participation in state-based reforms. That pattern is also likely to emerge as states begin working with health plans to develop health insurance exchanges.

Several of the states organized formal quality councils to promote positive stakeholder engagement. They recognized that delivery system reform cannot happen with the state working in isolation. It requires at least the commitment of purchasers, plans, and providers, and often the engagement of consumers. Phil Kalin and Jay Want, executive director and board chair of CIVHC, respectively, and Colorado's SQII co-team leaders note, "We think about building public will. We try to have discussions around the state about making choices. We have a view that if you get enough of the right people in the room, you can really move forward." Colorado also had access to financial support from the active foundations in the state. In times of budget deficits, innovative engagement with foundations can be one way for states to maintain support and momentum for their reforms.

The role of stakeholders is particularly important when one considers the long-term nature of delivery system reform as compared with shorter-term election cycles. The importance of strong political leadership for setting a reform agenda and providing consistent support for that agenda cannot be overstated. Nevertheless, it is important to recognize that political leaders change and priorities can shift, as can the resources at their disposal. The tenure of private-sector leaders and groups can span many gubernatorial administrations, and those leaders can have a powerful influence on the success of both legislative initiatives and the implementation of reforms that have been enacted. States pursuing such efforts would be well served to seek stakeholder input and support early and often.

Leadership

Craig Jones believes that a key ingredient to Vermont's success has been "consistently strong leadership at the state level; (having) a governor and legislature willing to stay committed to this, to not back down during tough fiscal and political times has been key." He acknowledges that many attribute Vermont's success to its small size and progressive culture, but insists that those conditions are not sufficient without the presence of strong leadership.

In states without term limits, a strong leader in the legislature can bring needed longevity and subject area expertise. Massachusetts, Vermont, Minnesota, and Oregon all had long-standing committee chairs in the area of health care who were important champions in promoting reform.

By contrast, Kansas saw significant turnover in leadership that curtailed many of its efforts. The state started the SQII with the support of Governor Kathleen Sebelius, who was knowledgeable about and committed to improving the health care system. The reform work of the Kansas Health Policy Authority (KHPA) was also supported by a moderate Republican leader in the legislature. In a short period of time, KHPA lost both their legislative champion as well as Sebelius who was called to serve as U.S. Secretary of Health and Human services. As a result, when the state faced a prolonged period of budget shortfalls, both staff and program funds for health reform were reduced.

Throughout the SQII program, state representatives and faculty talked about two types of leadership as being necessary for successful reform: 1) political leadership; and 2) project management leadership that keeps both state officials and stakeholders on task, accountable, and moving toward a shared goal. Though political leadership is important, states also need to invest in staff with the dedicated time and skills needed to lead a complex but collaborative decision-making and implementation process.

Investment in Data Collection and Analysis

The rigorous generation of appropriate data can provide a unique, nonpartisan impetus for reform and can provide a critical feedback mechanism once a reform effort is underway. The data can then be used to illustrate which efforts are effective in achieving the goals of the initiative, and which need to be modified or adapted mid-stream.

Because avoidable readmissions were a high cost driver in the state, the Health Data Consortium of Massachusetts identified transitions of care as an area where the state should focus its efforts. They did this through strong state regulatory actions and through participation in the STate Action to Avoid Rehospitalizations (STAAR) program.[8] Similarly, Minnesota has a strong data consortium called Minnesota Community Measurement. They define themselves as a "collaborative effort" in a community of "those who believe that you cannot improve what you don't measure."[9] The group brings together providers, purchasers, plans, consumer groups, and quality improvement organizations to promote greater transparency in the belief that this focus on data and transparency will lead to better health outcomes. Common quality measures are the cornerstone of Minnesota's medical home and provider tiering efforts.

Vermont has an all-payer claims database (APCD), which it uses to measure the cost impact of the Blueprint, and to produce valuable reports on the performance of participating providers.[10] Recognizing the importance of a strong data infrastructure to support decisions, Colorado and Oregon both passed legislation during the course of the SQII to initiate an APCD. Both state team leaders counted this as an important success. Barbara Langner, the Medicaid director in Kansas (which also has an APCD and has invested significant

resources into its ability to use and analyze data) and SQII team member, stated that better access to data has enabled them to identify key cost drivers so they can target efforts more effectively to achieve meaningful savings. By the end of the SQII, seven of the eight participating states had some form of an APCD.[11]

Commitment to Multi-Payer Payment Reform

Nothing gets the attention of health care stakeholders like payment reform. Although it is not sufficient for achieving successful reforms (providers also need data and training on how to transform their practices), it does demonstrate a commitment to pay for quality (not volume) and to support more transformational change. Reform also marks a turning point in the way a state does business, and effectively requires that key stakeholders come to the table.

Payment reform that extends beyond Medicaid or other government payers is also critical. If the goal is to change the behavior of providers (who likely see fee-for-service patients as well), payment signals must be consistent over a sufficient number of payers. This type of comprehensive payment reform can be seen in the Vermont Blueprint, and also in the Minnesota provider tiering and health care homes initiatives.

Washington State also has pursued an innovative patient-centered medical home pilot, which is an example of how advanced payment reform principles can be brought together with strong training, data collection, and evaluation to create a promising medical home model. Washington began by selecting more than 30 practices to participate in a transformation project. Though it did not involve a change in payments, it did provide practices with training and technical assistance. At the same time, Washington state officials also began working with payers, plans, and providers to develop a new payment model. As has been an issue for many, the state faced the challenge of plans not wanting to increase payments without holding providers accountable for results. Providers, on the other hand, were concerned about the start-up costs that would be needed to make the necessary changes that could achieve results.

Ultimately, the state developed a payment model that offers primary care physicians the opportunity to share in the savings if their patients have fewer preventable emergency room visits and avoidable hospital admissions. In addition to the components described above, the Washington program also includes patient and provider surveys to assess satisfaction, the tracking of clinical process and outcome measures, and the provision of ongoing access to performance data for providers.[12]

Before undertaking a multi-payer initiative, states should consider the payer dynamic in their state. In states without a dominant payer, health plans are accustomed to operating in a highly competitive environment, and it can be difficult to get them to start working together. In other states, such as Vermont, the dominant health plan can be an important partner in advancing reform. Joel Weissman, former senior health policy advisor to Massachusetts' secretary of health and human services and SQII co-team leader, underscores the importance of getting all payers on board: "We can't change the health care delivery system one payer at a time. We have seen decades of payers doing different things, and it doesn't have any lasting impact until all payers act in unison."

Barriers to Success

Changing the status quo is never easy, especially in an environment as complex as the U.S. health care system. It is much easier to block change than to be an agent of positive reform. Not surprisingly, the SQII states also faced barriers to success over the course of the initiative.

Fiscal environment: All states were hit by the tidal wave of the economic downturn, some harder than others. The poor economy meant that states were unable to invest resources in new initiatives; they had to figure out ways to start new projects with existing funds. They were also stymied in their effort to garner private funds, since health care stakeholders also had new worries about the bottom line. Ohio was one of the states hardest hit by the recession. Amy Rohling McGee, former health policy advisor to Governor Ted Strickland and Ohio's SQII team leader, pointed out that the inclination of insurers (for example) to take on the modest financial risk posed by payment reform related to medical homes was likely limited by each insurer's financial situation. Kansas felt that its reform effort suffered a substantial setback by state budget problems. Conversely, Richard Onizuka, director of health care policy for the Washington State Health Care Authority and that state's SQII team leader, noted that the state's severe budget deficit may actually have spurred more aggressive action on cost-saving and quality improvement initiatives than would have occurred in a less dramatic fiscal environment.

Health information technology: Hunt Blair, Vermont's lead on health information technology and SQII team member, indicated that, until recently, a major barrier to achieving delivery system reform was the limited capability of its health information technology systems. While the state is seen as a leader in this area—they have a state-wide fund that supports HIT development, a state-supported registry for Blueprint providers called DocSite, and significant statewide effort on health information exchange—they are still being slowed down by the need to create patches for systems that are being marketed as more sophisticated and interoperable than they actually are. State officials have been forced to take on the role of helping to facilitate conversations between health care providers and data/technology experts to ensure that essential fixes are made.

Unclear lines of responsibility and accountability: States are one player in a dynamic and complex health care economy. The state teams in the SQII were facilitators, conveners, and role models, but it was rare that they directly required action or could hold various stakeholders accountable for participation and outcomes. Even when a state is directly purchasing health care services (a scenario in which they presumably have more direct control), they are often working through intermediaries such as managed care plans and other private contractors. This makes it harder to directly influence the nature of the contracts being developed with providers and thus influence the way care is being provided.

Loss of momentum: System reform is extremely complex and it is easy for a state to lose momentum in the face of opposition, competing health reform priorities, and/or the difficulty of the tasks involved. Managing the pace of change becomes a significant leadership challenge. At times, some stakeholders may purposely slow down the deliberative process as a tactic for preventing reform. In other cases, stakeholders may be eager for change but become frustrated with the pace of progress. In many cases, states are managing a range of expectations, goals, and levels of eagerness for reform; keeping stakeholders on task and working together is not easy.

Need for additional measures and best practice standards: When asked about barriers to reform in her state, former Minnesota Health Commissioner and that state's SQII co-team leader Sanne Magnan responded, "Patient experience measures are not at the level they need to be. We don't have a primary medical home measure for patient experience yet. This is a national issue, but moving slower than we would have liked."

Colorado co-team leader Phil Kalin feels that states are still limited by the lack of evidence. "There is nothing you can point to and say, 'This is what we should be doing, it's clear, there is good empirical evidence, so we should line up behind this.' It is more amorphous now."

On the other hand, the limitations in the evidence should not be overstated or given as a reason for complete inaction. There was general agreement among states on the need to experiment and then evaluate new programs and ideas. When Vermont was considering taking their Blueprint model statewide during the 2010 legislative session, some counseled caution given that there has not yet been time to collect sufficient data to prove that the (chronic care) model saves money. Don George, president and CEO of BlueCross/BlueShield of Vermont, came out in support of expanding the program saying, "We know what doesn't work, and that is our current system."

Consumer engagement: In general, states struggled with the best way to educate and engage consumers. Clearly, consumer attitudes and expectations are critical to the success of reform, but states had difficulty deciding when and how best to effectively communicate and work with representatives from the patient and consumer communities.

Helping States Achieve Successful Delivery System Reform

The fate of many provisions within the federal Patient Protection and Affordable Care Act (ACA) have fallen largely into the varied and complex context of state policymaking. National nonprofit organizations and state and local foundations are looking for ways to help equip states for the task ahead. Federal policymakers, too, want to empower states to successfully implement all aspects of the ACA, including insurance market reform, implementation of health insurance exchanges, and the type of cost containment and quality improvement efforts undertaken by states in the SQII. To this end, the SQII offers some valuable "lessons learned" for those working in states.

Real-time peer-to-peer learning: In a context in which policymakers are learning as they go (some evidence is available, but there are no definitive answers), learning from the on-the-ground experience of others in nearly real time is critical. Phil Kalin of Colorado says, "SQII really allowed us to be able to talk to group leaders and see where our efforts overlapped with others, see how others are approaching things, and building relationships across the country with people and organizations that are doing similar work and really build a learning community." Jay Want of Colorado laments, "After going to the first SQII, I came back with APCD envy." (As a result, Colorado passed legislation the following year to authorize development of an APCD in the state). "I always look to states ahead of us or dealing with the issues we are dealing with," says Richard Onizuka of Washington. The technical assistance providers were also able to bring to light examples from leading states not involved in the SQII. Technical assistance providers also facilitated contacts between state officials from SQII states and non-participating states, such as Pennsylvania and Rhode Island, resulting in additional sources of on-the-ground experience for the SQII states.

Mutual support: Dr. Want also talks about the difficulty of going against the flow of 'business-as-usual.' "Most of the people going to SQII meetings are looking to the future, so they look mildly to moderately insane to stakeholders back in their own states. If a bunch of crazy people are moving in the same direction, you can all be crazy together." The status quo is often everyone's fallback option, and so champions of change need mutual support if they are to remain bold and persistent.

Small group meetings: The SQII offered small topic-based meetings that included four to six people from three states and a handful of faculty experts. The total number of participants was around

30. These meetings allowed in-depth interaction and conversation, not just the question-and-answer that occurs in larger meetings. They also allowed participants to dig into the detailed, operational aspects of the selected topics. The states learned from the experts, but also from each other. Formal opportunities were provided for states to present their own challenges and to allow the other participants to ask questions and offer suggestions. The evaluation responses for these meetings consistently cited them as being one of the most valuable avenues for providing technical assistance.

Expert faculty: The reality is that every reform effort will encounter roadblocks along the way. Support and advice from outside experts can be critical for moving past obstacles. When Washington was setting up the payment reform component of their patient-centered medical home, they came to an impasse between the payers and providers. Both public- and private-sector leaders in Washington met with national payment reform experts, which helped them work out a compromise between payers and providers and the project regained momentum.

Safe environment for team learning: The SQII always allowed states to bring teams of people to meetings, providing them with the designated space and time to talk and brainstorm among themselves. It offered a protected opportunity for state leaders to talk about ideas and strategy without the demands of schedules, meetings, and deadlines associated with their "day jobs." When teams attend meetings together, they all have access to the same information, time to synthesize and contextualize together, and can more easily develop shared objectives. When the Ohio team attended its first SQII meeting, the team did not have consistent goals. They left the meeting with a shared plan for a Summit, which ultimately set the stage for conversations and work groups around delivery system reform in the state. Two years after their first meeting, through the work of the committee that grew from their initial Summit, the state now supports a medical home pilot and has recently joined the Institute for Healthcare Improvement's STate Action to Avoid Readmissions (STAAR) initiative.

In-state meetings with outside experts: Several states pointed out that having external experts visit their state was extremely helpful for a variety of reasons. First, in-state meetings allow state officials to invite multiple stakeholders who can all benefit from the outside expertise. Second, the cachet of having a national expert associated with a national program is always helpful for raising the profile of a meeting or initiative. Third, they can help to contextualize and legitimize the policy direction in which the state is moving. "You are never a prophet in your own land!" observes Ohio's Rohling McGee.

Well-tailored and targeted technical assistance: Successful technical assistance providers must listen to those they are trying assist. The SQII became relevant by answering the questions states were asking and responding to the dilemmas they were facing. Gretchen Morley, director of health policy development at the Oregon Office for Health Policy and Research and that state's SQII team leader, noted that, especially as states faced tight budgets and limited staff resources, "What helped was our relationship with (the SQII team); knowing that we have you all as a resource, and having you tailor the assistance."

Accountability: The SQII team learned about the need to balance an approach that responds to the expressed needs of states and that holds state teams accountable for their active participation in the program. Strategic plans and timelines are effective tools for achieving system change. In some cases, state officials benefit from being held accountable for creating and revisiting these documents. It is also easy for state staff to get stuck in the infrastructure of their own agency or hierarchy. By consistently asking for cross-agency team participation, the SQII sought to combat this tendency.

A Note about the State Staff Who Effectively Led SQII Teams

These lessons learned are not meant to give all the credit for state success to the SQII program. The SQII staff was consistently humbled and amazed by the dedication, talent, and technical skill that their state partners brought to the task of system change. The SQII team observed that there is no substitute for effective and knowledgeable staff at the state level.

The need to train and retain effective staff will be particularly important as states seek to implement the ACA in the wake of recent (and ongoing) budget cuts and hiring freezes. The SQII team holds the view that effective TA must equip state leaders for the challenging task ahead rather than simply doing the work for them. As states obtain more federal funding to hire consultants, it will be important for state staff to consider ways that consultants can expand their capacity without simply taking the expertise outside of state government.

Conclusion

Delivery system reform is a complex, multi-stakeholder, long-term process. Keeping reform on track in spite of the many barriers that can arise will be an enormous challenge for states in the years ahead. Nevertheless, technical assistance providers can help make states more successful by listening to them, convening them to learn from each other, providing them with needed expertise, and helping them overcome inevitable hurdles. Though it signals a time of great

opportunity, the ACA also brings new challenges for states: they will not only need to coordinate with others in the state but —to an even larger extent than before —they will need to coordinate with federal officials. As we look ahead to this challenge, a quote from Craig Jones, Vermont team leader, is instructive: "If you view state-led reform as hand-in-hand with federal reforms, then technical assistance would foster maturity of relationships between federal and state governments. States are a transformation engine and federal guidance is behind it. If you were to foster interaction, it would help states move to the next level. We are moving to a stage where it is not states swimming upstream, but they are swimming with the platform of the ACA, ONC, and AHRQ. The focus of the assistance needs to foster that."

About AcademyHealth

AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading nonpartisan resource for the best in health research and policy. With a growing membership of more than 3,500 researchers and other experts in health care, AcademyHealth promotes and facilitates interaction across the health research and policy arenas. www.academyhealth.org

Endnotes

1. New Mexico did not continue through the entirety of the project.
2. The Triple Aim concept was developed by the Institute for Healthcare Improvement (IHI); it is the simultaneous pursuit of three aims: improving the experience of care; improving the health of populations; and reducing per capita costs of health care. See http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm.
3. The Chronic Care Model was developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and colleagues of the Improving Chronic Illness Care program with support from The Robert Wood Johnson Foundation. It is defined by the following characteristics: self-management, decision support, delivery system esign (which includes a team-based approach to care and a commitment to outreach), clinical information systems (or registries), organization of health care (to insure that care is coordinated and not haphazard), and community (health organizations work with other community groups to promote population health). For further information, see http://www.improvingchroniccare.org/
4. In 2004, the state joined with private health care purchasers to develop the Smart Buy Alliance which agreed to uniform performance standards, cost and quality reporting requirements, and technology demands on health plans and providers. Those participating in the Smart Buy Alliance rewarded providers and plans that could show they were providing high quality care. *Minnesota's Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care;* May 26, 2005. http://www.commonwealthfund.org/Content/Innovations/State-Profiles/2005/May/Minnesotas-Smart-Buy-Alliance--A-Coalition-of-Public-and-Private-Purchasers-Demands-Quality-and-Effi.aspx
5. Minnesota Department of Health, *2008 Health Care Reform Summary;* June 2008. http://www.academyhealth.org/files/SQII/MNHealthReform2008Summary.pdf
6. The Ohio Health Care Coverage and Quality Council was created during the course of SQII while the Center for Improving Value in Health Care (CIVHC) began just before Colorado joined SQII. Colorado used the resources of SQII to educate and support the work of CIVHC.
7. Note that insurers in Massachusetts and Minnesota are nonprofits.
8. Funded through a grant from The Commonwealth Fund, the Institute for Healthcare Improvement's STAAR initiative aims to reduce rehospitalizations by working across organizational boundaries by engaging payers, state and national stakeholders, patients and families, and caregivers at multiple care sites and clinical interfaces. http://www.ihi.org/IHI/Programs/StrategicInitiatives/StateActiononAvoidableRehospitalizationsSTAAR.htm
9. MN Community Measurement. http://www.mncm.org/site/?page=about
10. Department of Vermont Health Access, *Blueprint for Health 2010 Annual Report;* January 2011. http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf
11. The one exception is Ohio. Washington has the Puget Sound Health Alliance, which is a voluntary organization of payers, plans, and providers in which the state participates. Because participation in the claims database is voluntary, there are limitations on the uses of the data and not all claims in the state are included. Oregon and Colorado are still developing their all-payer claims databases. Minnesota limits the use of claims data to their provider tiering project; all other uses are not permitted.
12. State of Washington, Final Update on SQII Project. Presentation at the SQII Final Meeting, June 14-15, 2010. http://www.academyhealth.org/files/SQII/WAFinalMeeting.pdf