

Regional Coalition Collaboration Guide

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Chapter 1. Introduction

Value-Driven Health Care

The Value-Driven Health Care Initiative launched by the Department of Health and Human Services (HHS) is designed to help achieve high-quality, cost-effective care for patients. Through a collaborative process that brings together community stakeholders, such as providers, employers, health plans, and consumers, the initiative will drive clinical quality improvement by providing the public and providers with reliable and consistent health data.

An essential component of implementing value-driven care is creating a national network of regional coalitions. By making comparable information widely available at the local level, regional coalitions are crucial to helping stakeholders make informed health decisions and improve health care quality on a broad, systemic level. They accomplish this important goal by fostering collaboration across multiple stakeholders in the community and facilitating four national cornerstone actions designed to enhance the effectiveness of our health care system:

1. Connecting the system through health information technologies.
2. Measuring and publishing quality data based on agreed-upon standards.
3. Measuring and publishing price information for specific services to patients.
4. Creating positive incentives that reward high-quality, cost-effective care and encourage consumers to actively choose the care that meets their needs.

The Community Leader's Role

An important first step to forming a regional coalition for this initiative is for HHS to recognize a community group as a community leader. These local, multiparticipant organizations are designated Community Leaders because they demonstrate the capacity for developing key characteristics of a regional coalition, including:

- Actively engaging with critical stakeholders in the community.
- Facilitating the collection of provider-level measurement across the six Institute of Medicine performance domains (safe, timely, effective, efficient, equitable, and patient-centered).
- Using, or promoting the use of, performance measures for:
 - Publicly reporting costs and consumer satisfaction.
 - Rewarding and fostering better performance.
 - Provider improvement.
- Fostering collaboration across multiple stakeholders and serving as a hub for sharing information and dialogue.

The initial stages of forming and maintaining these and other aspects of a regional coalition can be challenging for Community Leaders. This guide is a compilation of insights and lessons learned culled from six established regional coalitions to help guide Community Leaders as they begin to formulate strategies for developing their own coalitions.

The Better Quality Information Project

Several regional coalitions currently are operating around the country. The Ambulatory Care Quality Alliance and the Agency for Healthcare Research and Quality (AHRQ) selected the six groups represented in this document to participate in the Better Quality Information (BQI) to Improve Care for Medicare Beneficiaries Pilot Project. The pilot sites in this national project sponsored by the Centers for Medicare & Medicaid Services are:

- The California Cooperative Healthcare Reporting Initiative, San Francisco, California.
- The Center for Health Information and Research-Arizona State University, Tempe, Phoenix, Arizona.
- The Indiana Health Information Exchange, Indianapolis, Indiana.
- Massachusetts Health Quality Partners, Boston, Massachusetts.
- Minnesota Community Measurement, St. Paul, Minnesota.
- The Wisconsin Collaborative for Healthcare Quality, Madison, Wisconsin.

Before the Ambulatory Care Quality Alliance and AHRQ selected these coalitions as BQI sites in 2006, each community group had independently brought together a variety of constituencies to combine public and private data for measuring and, ultimately, reporting on physician practice in its geographical region.

Lessons Learned From BQI Sites

As a way to capture and share with Community Leaders the rich knowledge these six pilot sites have gained through successfully building and managing regional coalitions, AHRQ has collaborated with the Delmarva Foundation to produce this broad compilation of essential lessons learned.

Because each coalition is unique in its specific regional setting, this guide is not intended to be a one-size-fits-all toolkit or a detailed “how-to” guide. Rather, the information captured from the BQI sites is organized around key issues of interest to Community Leaders that are in the process of forming a coalition. Community leaders will need to apply these general lessons on leadership skills, establishing the coalition’s credibility, building trust among stakeholders, and communication to their own circumstances. For further reference, the appendices include overviews for each BQI site, a chart comparing the sites, the framework behind the site visits, summaries of the site visits, a list of mentors who Community Leaders may contact for advice, and resources.

This guide will assist Community Leaders in taking the crucial first steps in creating and sustaining a regional coalition. It is through the vision, leadership, and hard work of Community Leaders that the Value-Driven Health Care Initiative will successfully transform American health care into a truly value-driven system.

Chapter 2. Leadership

Effective leadership skills are essential for developing and maintaining something as large and complex as a regional coalition. Strong leadership not only visualizes what can be achieved but also creates a supportive organizational structure that fosters the environment necessary to make the vision a reality.

Vision, Mission, and Values

An important first step in establishing a coalition is to define its vision, mission, and strategic values. A vision statement clearly and broadly captures what the coalition aspires to become, and the mission is an enduring statement of purpose that describes the coalition's reason for being. Both the vision and the mission statements reflect the coalition's values, which guide how it operates and succinctly present its underlying philosophy.

Each element helps provide the coalition with a shared sense of purpose and direction. Clearly stating the coalition's guiding purpose and overarching vision provides the often disparate members of a regional coalition with a common goal to aim their energy and resources. It also can help to maintain the coalition's focus during difficult times and keep staff motivated with an inspiring objective, such as contributing to the greater good by improving health care.

The following example from Massachusetts Health Quality Partners illustrates how one Better Quality Information (BQI) site presents its vision, mission, and statement.

Our Mission

Massachusetts Health Quality Partners' mission is to improve the quality of health care services delivered to the residents of Massachusetts through broad-based collaboration among health care stakeholders.

Our Vision

Massachusetts Health Quality Partners' vision is to be the premier health care quality collaborative in Massachusetts, including the most trusted and influential source for comparative health care quality performance information.

Our Values

We believe in the power of collaboration.

We believe our work should have a measurable impact and be evidence based.

We believe that eliminating unnecessary duplication and improving efficiency are key components to quality improvement.

We believe that credible performance information supports improvement.

We believe that educating the public about health care quality, including appropriate public release of performance information, supports quality improvement and enhances public accountability.

We believe that engaging health care providers and consumers in an open dialogue about performance information is a critical part of the quality improvement process.

The Massachusetts Health Quality Partners board of directors has identified the following five strategic focus areas in support its mission:

1. Take a leadership role in building collaboration and consensus around a common quality agenda.
2. Aggregate and disseminate comparable performance data.
3. Increase coordination and reduce inefficiencies to improve the quality of care delivery.
4. Develop and disseminate guidelines and quality improvement tools.
5. Educate providers and consumers in the use of information to support quality improvement.

The Need for Visionary Leadership

Forming a regional coalition requires dynamic, dedicated, and visionary leadership that can bring together a diverse group of stakeholders. The need for visionary leadership was a recurring theme among the BQI sites, particularly during each site's startup phase.

What is "visionary leadership?" A visionary leader has a sharp understanding of a current reality that needs improvement and offers a vision for how to improve it. Visionary leaders also inspire, influence, and guide others in helping work toward making this vision a reality.

In creating a shared vision, leaders answer such basic questions as, "Where are we going" "What are we trying to do" and "Why."

The BQI sites typically identified individuals who possessed visionary qualities. These leaders recognized the need for change early on and played an essential role in envisioning and establishing the coalition. Leaders of BQI sites typically:

- Have a highly respected reputation among influential stakeholders in the local health care community and are capable of getting buy-in.
- Possess the ability to articulate the vision of the coalition persuasively and enthusiastically to a variety of constituencies and are able to motivate action.
- Are tirelessly persistent in promoting the need for a regional coalition, its activities, and its objectives.

Examples of Effective, Visionary Leaders

Massachusetts Health Quality Partners. Massachusetts Health Quality Partners began in 1994 with the visionary leadership of the late H. Richard Nesson, M.D., then-board chair of the Massachusetts Hospital Association Board. After the *Boston Globe* printed data that gave the wrong impression about mortality rates in Massachusetts hospitals, Dr. Nesson used the opportunity to build support among a variety of constituencies for creating a coalition to measure themselves and be accountable to the public by publicly reporting performance results.

Minnesota Community Measurement. Minnesota Community Measurement was created as a result of visionary, can-do leadership seizing the opportunity to proactively bring groups together to improve health care in the region. In 2001, three medical directors of the largest health plans in Minnesota informally met while attending the Institute for Healthcare Improvement's annual conference in Florida. Over coffee, they discussed how the health plans could more effectively use Healthcare Effectiveness Data and Information Set (HEDIS) data to improve health care in Minnesota.

Gail Amundson, M.D., a medical director from one of these large health plans, had the vision of aggregating health plan quality of care performance data and reporting it at the medical group practice level. The trio of medical directors met throughout the following year to develop a pilot proposal to report the HealthPartners HEDIS-Plus Optimal Diabetes Care measure by medical

group practice. Dr. Amundson led the Medical Director Team and Data Planning Team, both of which contributed many hours and much talent to making the pilot successful. That pilot eventually grew into Minnesota Community Measurement.

Wisconsin Collaborative for Healthcare Quality. Two sparks ignited the formation of the Wisconsin Collaborative for Healthcare Quality. One was the publication of Wisconsin's first comparative performance report by The Alliance, a Madison-based business health care coalition. Using a public-use dataset of administrative claims, this report focused on hospitals and was a clear indication of the business community's desire for access to comparative performance information. At the same time, the State of Wisconsin was preparing to implement a law mandating the collection of administrative claims data from medical groups.

Astutely discerning the implications of these two events, John Toussaint, M.D., president and chief executive officer of ThedaCare, an integrated delivery system in Appleton, called his peers at several other systems in Wisconsin, including the Marshfield Clinic, Gundersen-Lutheran in LaCrosse, the Medical College of Wisconsin in Milwaukee, and Dean Health System in Madison, and shared his vision of a voluntary collaborative effort that brings together physician groups, hospitals, and purchasers to design and report accurate and actionable comparative performance information. This vision served as the genesis of the Wisconsin Collaborative for Healthcare Quality.

Leadership Tips

Go Slowly at First

Setting the right tone in the relationships you initiate as a coalition leader will go a long way in establishing your reliability and trustworthiness. As part of your leadership style, BQI leaders recommend forming the coalition at a pace that is conducive to building relationships and instilling trust and credibility as honest brokers in the coalition.

In addition to promoting the coalition's vision, take the time to define clearly what the expectations will be for potential participants while cultivating the common ground among various groups. Massachusetts Health Quality Partners was "in business" for 5 years before it became incorporated as a nonprofit organization. The coalition focused on developing small, achievable projects to secure early successes.

The Wisconsin Collaborative for Healthcare Quality started with nine health care organizations located in separate geographic markets. The leaders of these organizations agreed to limit participation during the first year (2002) to determine the feasibility of collaborating on a performance measurement. As word began to spread about the meetings among the nine organizations and their business partners, there was considerable pressure from other health care organizations that wanted to become involved. The founders held firm until the group's first public report was issued and then decided to become a membership organization. Although the decision was difficult, it did not preclude the Wisconsin collaborative from growing rapidly once others were invited to join.

Assess Participant Core Competencies

Leaders should identify skill sets of participating members. Just as having a technically skilled staff enhances trust among stakeholders, identifying who among your stakeholders has the well-

developed technical and collaborative skills necessary to complete tasks efficiently and effectively can strengthen the coalition's integrity.

Be Prepared to Address Stakeholder Concerns

As a leader, your ability to successfully address and resolve participant concerns is crucial for maintaining the coalition's credibility. Before engaging potential stakeholders, be prepared to welcome concerns and criticisms from participants and have transparent processes in place to resolve issues quickly. This approach will establish the coalition's collaborative image among participants and may win over critics. Coalition leaders in Minnesota found that their willingness to openly engage on and learn from the concerns critics raised actually moved many initial critics from resistance to full engagement in the coalition.

Develop Processes for Addressing Mistakes

Strong leadership depends on anticipating mistakes and addressing them while minimizing damage to the coalition's credibility. Developing processes early that openly and quickly correct mistakes is vitally important. Leaders in the California coalition, for example, encourage developing a policy of acknowledging to stakeholder groups when mistakes occur as soon as they happen. After notifying participants of a mistake, the team quickly works to correct it and communicates the resolution immediately to stakeholders.

For example, when the California Cooperative Healthcare Reporting Initiative's copying service experienced equipment problems, the coalition was unable to return charts to participants on time. Although this glitch caused anxiety among participants, staff members helped allay the stress by honestly acknowledging the situation to the participants and sending frequent updates on how the problem was being resolved.

When the Massachusetts Health Quality Partners' Web site crashed on the day it was to publicly release data, the coalition received numerous calls from angry people who found the site down. Staff members phoned and e-mailed each caller to apologize and explain what had happened. Many callers were pleasantly surprised by this personal contact and were left with a positive impression of the coalition, thereby helping to maintain trust.

Tip: Actively solicit direct, honest feedback from stakeholders by maintaining an open, ongoing dialogue with them.

Chapter 3. Developing and Maintaining Relationships

Recruiting

Assess Your Regional Environment

Before initiating relationships with potential coalition stakeholders, it is important to assess your region's business environment. An environmental scan can range from having informal conversations with key business leaders in your region to developing a formal market research methodology. Performing ongoing investigations in the community will provide coalition leaders with information about the larger external environment that will help them develop strategies that address unique needs, opportunities, and competition in the community.

This research also can provide coalitions with insight into the cultural context within which they operate. Different parts of the country will have distinctive cultural norms, and coalition leaders will need to develop appropriate approaches to building relationships.

For example, Better Quality Information (BQI) sites in the Midwest successfully leverage the inherently collaborative culture in this part of the country. In particular, Minnesota Community Measurement did not encounter some of the competitiveness that other sites did because the health care system in Minnesota is not for profit. Consequently, from the outset stakeholders were more inclined to collaborate on health care quality, and leaders developed a strategy based on this knowledge.

Persuasion Versus Coercion

Regardless of geographical location, an important part of building a regional coalition is the ability to persuasively communicate to stakeholders your vision and the benefits of contributing data. Persuasion, which by definition is nonadversarial, is better suited to the collaborative nature of coalitions than threats that underlie coercive tactics. BQI leaders agree that coercion and the "hard sell" are not as effective in building relationships as appealing to how the coalition will serve the potential participants' interests.

From the first contact with stakeholders, be as transparent as possible about what the coalition hopes to accomplish, acknowledging tensions, concerns, and competitions up front and candidly. It also is advisable to cultivate relationships with influential senior leaders in the organization you want to recruit. These senior leaders, in supporting the coalition's objectives, can become advocates for others to join the coalition.

Lastly, it is helpful to develop a list of selling points that communicate the value stakeholders will receive when they participate in a regional coalition. For example, selling points that the Center for Health Information and Research in Arizona used to bring stakeholders together include:

- Providing a snapshot of how their individual data compares to deidentified competitors to allow stakeholders to see a more comprehensive picture of care in the community.
- Emphasizing how data sharing will enhance care by tracking patients in the community who move around to different emergency rooms in the area.
- Making the case for how joining the coalition will contribute to tracking regional statistics of who gets care, what kind of care, what the costs are, and so forth, all of which contributes to reforming the national health care system.

Key Groups

When identifying potential participants, coalition leaders should consider a broad and diverse group of organizations that contribute data to ensure a more comprehensive set of data. In addition to health plans, hospital associations, and physician groups, the following groups and organizations in your community are important stakeholders with whom to cultivate relationships:

Business Coalitions

Minnesota Community Measurement partners with the Buyers' Healthcare Action Group, an important business coalition in the community in Minnesota. Working synergistically, the two groups have moved the health care quality improvement missions of both organizations forward expeditiously and in a way that reduces confusion and redundancy in the marketplace.

The Wisconsin Collaborative for Healthcare Quality benefits tremendously from the collaboration between physicians and one of its business partners, The Alliance. An employer-owned and -directed cooperative, The Alliance works to obtain affordable, high-quality health care for the 105,000 employees and dependents of its 170-member employers. Unique to BQI sites, this employer-driven group runs a portion of the data analysis for the Wisconsin collaborative.

The Pacific Business Group on Health, a business coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost, founded and currently manages the California Cooperative Healthcare Reporting Initiative.

Quality Improvement Organizations

In each State, Quality Improvement Organizations (QIOs) work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems so patients, particularly those from underserved populations, get the right care at the right time. (For a comprehensive list of QIO listings, visit www.MedQIC.org.) The QIOs also safeguard the integrity of the Medicare Trust Fund by ensuring payment is made only for medically necessary services and investigating beneficiary complaints about quality of care.

Coalition leaders should consider having discussions with the local QIO early in the convening process to determine how they can work together. For example, from the beginning, Minnesota Community Measurement has had a good working relationship with Stratis Health in Minnesota and finds the QIO helpful in breaking down complicated quality issues. Stratis Health staff serve on Minnesota Community Measurement committees and have a seat on its board of directors.

Some of the BQI sites have encountered resistance from QIOs or have found that because the QIO's focus is concentrated on its scope of work, it is unwilling or unable to work with coalitions. Consequently, some relationships with QIOs range from partnerships to informal relationships. Massachusetts Health Quality Partners currently is partnering with MassPro (the Massachusetts QIO) and the Massachusetts Medical Society to develop a quality improvement curriculum that integrates improvements in clinical quality with improvements in patient experience. The Indiana Health Information Exchange has a cooperative relationship with Health Care Excel (the local QIO), but the two organizations have yet to establish an official business relationship.

Medical Associations

Although some associations initially may be reluctant to join the coalition, coalition organizers can emphasize the inevitability of public reporting and how the association's early involvement will help to define and influence the process and eventual product. Medical association participation also benefits the coalition. For example, having the Minnesota Medical Association at the table gave physicians a voice on Minnesota Community Measurement committees. The Minnesota Medical Association, a founding sponsor, also holds a seat on the Minnesota Community Measurement board of directors. Consequently, the Minnesota coalition gained credibility among physicians, which helped persuade others to participate. Similarly, the Massachusetts Medical Society was a founding member of Massachusetts Health Quality Partners.

Non-Health-Related Organizations

Part of building a community coalition involves developing partnerships with non-health-related organizations to capture as much data as possible. In Arizona, the Center for Health Information and Research, for example, has recruited a large, area supermarket to join its wide-ranging array of community groups and businesses that participate in its coalition. Having these kinds of partners on board broadens the data used in reporting.

State Legislature and Government Agencies

The BQI sites have found different ways of engaging their State legislatures and governments. Some have worked with the legislature to mitigate a lack of willingness to share claims data; however, others warn that although one legislative session can mandate sharing data, a subsequent session can reverse or modify the mandate.

Some sites have State officials as board members. This can add to the coalition's credibility. Massachusetts Health Quality Partners, for example, originally had two State representatives on its board—the medical director for Medicaid and a representative from the Department of Public Health—both of whom were able to represent the important public sector in Massachusetts Health Quality Partners' quality improvement work. Establishing relationships with commissioner-level officials early also is very valuable for enhancing the coalition's credibility.

Tip: Keep membership small at first. When first forming a coalition, the broader it is, the more difficult it is to get things done because your agenda will need to be broad to address all interests. It takes time to methodically build a broad coalition that is effective.

Selecting a First Project

The Importance of Early Successes

Having an early success is crucial during the formative stage of the coalition's development. Although the coalition's mission and vision may be inspiring, enthusiasm for the project will stall if results are slow in coming. A highly visible, unequivocal early success establishes the feasibility of

the coalition's goals, promotes rapport and trust, and builds excitement and momentum. It may even quiet critics.

For your first project as a coalition, identify an issue that is small enough to ensure success but dynamic enough to generate attention among stakeholders. It should be something around which various groups can coalesce and successfully accomplish together. The Indiana Health Information Exchange undertook a messaging project (discussed in Chapter 6) that was small but successfully built a bond among stakeholders.

An early success serves the dual purpose of demonstrating to stakeholders that the coalition is capable of delivering on its expressed goals and helping generate energy internally for the team. The Wisconsin Collaborative for Healthcare Quality convened in 2002 to announce its goal of producing a report within a year. This focus galvanized the coalition and gave all participants—provider organizations and business partners—something to work toward together as a way to build trust and translate a concept into reality.

Instead of beginning as a quality reporting group, the Center for Health Information and Research focused its first efforts in 1998 on promising to build a database, despite criticism that the data were too disjointed for such a resource. After establishing Arizona HealthQuery, which successfully integrated health claims records from public and private data sources into a database, the Center for Health Information and Research reinforced its credibility by then taking specific data requests—such as how many kids have asthma in a given location—and delivering a comprehensive number in 2 weeks.

Early failures, if handled properly, can also reinforce credibility and build rapport. Admitting openly and honestly when the coalition has fallen short in delivering on a promised goal demonstrates the team's commitment to transparency and improving the process. When the Center for Health Information and Research delivered the results of a data query at one of its data partner meetings, a partner pointed out that data were wrong. Upon reviewing the data at the meeting, the center acknowledged that the data interpretation was indeed wrong, adjourned the meeting, and sent a corrected report with a note explaining what was done to correct the data.

Maintaining the Coalition

Among the important factors involved in maintaining a coalition are demonstrating continuous value to stakeholders and cultivating trust. However, coalitions of all sorts can encounter general difficulties that can sap its vitality, such as poor group dynamics, lackluster participation from members, and unproductive activities. Specific challenges regional coalition leaders should be prepared to address include:

- **Timeliness.** Stakeholders do not always provide data on a timely basis. The Center for Health Information and Research has a standing schedule with its stakeholders for routine data transfers, but data partners often need multiple reminders. Recognizing the need to maintain a positive relationship, the center politely and persistently encourages them to contribute while considering the voluntary nature of their relationship.
- **Turnover.** High chief executive officer and chief medical officer turnover in stakeholder organizations can disrupt the continuity of the relationship. For some sites, these officials are the only members of their organizations involved in the regional coalition. In addition to working with chief executive officers, the coalition should find ways to communicate and engage with other senior leaders in stakeholder organizations as well, such as by contributing articles on the coalition to employee newsletters.

- Burnout. With stakeholders often participating in simultaneous collaboratives, answering numerous surveys, and serving on multiple committees, burnout can be a challenge. Be mindful of stakeholders' busy schedules and other commitments.
- Competition. When bringing together many different stakeholders, many of whom are competitors, identify areas where they compete and areas where they are willing to collaborate.

Tip: Involving chief executive officers in the collaborative process is important for some coalitions. Other coalitions have found that working closely with an organization's quality experts, such as medical directors, and periodically updating the chief executive officer is sufficient.

Chapter 4. Establishing Credibility and Value

Credibility

Establishing the credibility of your coalition is crucial to recruiting participants and effectively leading a regional coalition. Achieving credibility means having others recognize the coalition's capabilities and knowledge.

Business literature identifies numerous characteristics of organizational integrity, including accountability, honesty, candor, and transparency. A number of specific factors also affect the perception of a coalition's credibility, such as its process for data analysis and validation, how errors are addressed, and what experts and specialties support the initiative. Coalition leaders have identified the following approaches to enhancing credibility in the early stages of a coalition among stakeholders, the media, and the public.

Partner With High-Profile Organizations and National Initiatives

The Center for Health Information and Research used its involvement in national projects to help establish its credibility among major players in the Phoenix area. Its participation in a successful national quality initiative sponsored by CIGNA, for example, generated local interest in forming the Phoenix coalition. Partnering with a national human resources policy association also established its credibility among local employers. However, convincing large national plans to participate in regional coalitions can be challenging because their objectives sometimes conflict with regional goals.

Have Strong Connections Within the Local and Regional Community

To reinforce its integrity, an emerging regional coalition also should connect with credible organizations that have strong ties in the health care and business communities.

Health care community. Minnesota Community Measurement made a crucial, strong connection with the Institute for Clinical Systems Improvement, an organization in Minnesota within the physician and provider community. The institute works with medical groups to establish quality improvement cultures and infrastructures, including internal measurement. It also develops guidelines that are based on local and national best practices and use evidence-based processes. Minnesota Community Measurement bases its measures on these guidelines, which are approved by local and regional physicians. Aligning with this highly credible local organization strengthened Minnesota Community Measurement's credibility among physicians and providers. The coalition is working to cultivate consumer participation by reaching out to local organizations that consumers see as credible, such as the Minnesota chapter of the American Diabetes Association.

St. Luke's Health Initiatives, which helped to establish the Arizona HealthQuery with the Center for Health Information and Research in Arizona, also is well connected in the Phoenix health care community. It was able to draw stakeholders from its many contacts in the State's hospital and medical associations, the local Quality Improvement Organization, and the State legislature.

Because it realizes the importance of having valid and reliable measurements, Massachusetts Health Quality Partners has established relationships with many world-class health care researchers

in the Boston area. Massachusetts Health Quality Partners' credibility benefits from the experts' involvement in the data analysis portion of the research, and the researchers benefit from having access to a large, broad-based database.

The California Cooperative Healthcare Reporting Initiative works closely with the California Medical Association. A California Medical Association representative sits on the coalition's Executive Committee and provides perspective on issues that affect physicians. Additionally, the California Cooperative Healthcare Reporting Initiative also works closely with the California Association of Physician Groups to enable an efficient communication path to the physician groups and physician leaders within the State. The California Association of Physician Groups' medical director sits on the California Cooperative Healthcare Reporting Initiative's Better Quality Information Pilot Steering Committee.

Business community. The Wisconsin Collaborative for Healthcare Quality founders recognized the importance of building credibility and trust with the business community, a key customer of each member organization. Each founder invited a business partner to participate in all the collaborative's meetings, including those focused on selecting the initial performance measures. Business partners included private employers, business coalitions, a large union, and a State association of business and commerce. These invited partners connect the Wisconsin Collaborative for Healthcare Quality to each local market directly, enhancing the legitimacy of the collaborative's vision.

The Indiana Health Information Exchange has cultivated a relationship with the Central Indiana Employers Forum, which consists of several employers, hospitals, physician groups, and payers. The forum initiated development of a pay-for-performance quality health program led by the Indiana Health Information Exchange. Consequently, the coalition immediately gained the support of important players in the region. The Indiana Health Information Exchange also worked closely with the Central Indiana Corporate Partnership, an alliance of chief executive officers from the region's largest employers and its university presidents. Lastly, the Indiana exchange's board of directors includes hospital chief executive officers, the mayor of Indianapolis, local public service health care leaders, payers, and other people needed for ongoing support of the collaborative.

Emphasize the Collaborative Nature of the Coalition

Providers drive some Better Quality Information sites; purchasers drive others. Regardless of the driver, keep in mind the need for underscoring the value exchange's collaborative nature.

For example, professionals with medical experience drive the Wisconsin Collaborative for Healthcare Quality. This has given the coalition credibility among clinicians. However, coalition leaders recognize that to be truly effective, their efforts must be part of a larger community network. Consequently, purchasers also play a large role in influencing the direction and governance of the coalition.

Value

The success of a coalition will, in large part, be based on the value it can provide participants. Each major player in a multistakeholder coalition brings to the table a different agenda with key goals and objectives. A critical challenge for coalition leaders is to create value for each player in order to keep it at the table.

A critical step in forming a coalition and identifying stakeholders is developing strategies for addressing the “what’s in it for me” motive many will have. Identifying and communicating the value of the coalition and working to continuously provide that value will be one of the most important challenges in maintaining a coalition.

Show Value to Entice Participants

To attract purchasers as participants, the Wisconsin Collaborative for Healthcare Quality emphasized that participation in the coalition would allow access to comparative performance information that otherwise would not be readily available. Participation would also allow purchasers to directly influence the selection of performance measures. As a result, these stakeholders had an opportunity to improve their business based on information at their fingertips. This sort of value was an attractive incentive for purchaser participation, and it was important for the Wisconsin collaborative to highlight this value when inviting purchasers to join.

In addition to access to a rich compilation of data, one of the most appealing benefits a coalition can offer stakeholders is saving them time and money through services the coalition provides. When the Massachusetts Health Quality Partners initially formed, hospitals needed to respond to multiple requests from health plans for reporting hospital quality data. Hospitals became frustrated with the number of requests from different plans, which were redundant and resulted in wasted time and resources and increased frustration. The Massachusetts coalition was innovative in coordinating and streamlining the numerous quality data requests into a single format that all plans accepted. Health plans were satisfied because hospital quality data requirements were fulfilled in an accurate, concise format. Hospitals were relieved because now there was one convener—Massachusetts Health Quality Partners—between hospitals and health plans that alleviated some of the frustration and wasted resources while ensuring that reporting requirements were satisfied.

Streamline Complicated Processes

An effective way to demonstrate a coalition’s value to participants is to demonstrate how it will simplify data collection for them.

The Wisconsin Collaborative for Healthcare Quality has designed an innovative model of direct data collection from its participating medical groups. Through the development and application of an “all payer, all patient” method of measurement, medical groups collect both administrative and clinical data internally and submit calculated performance results to the collaborative through a secure, Web-based tool. This method obviates the need to aggregate administrative data from multiple health plans, incorporates clinical data for more robust measurement, creates a standard set of data files for validation and auditing, delivers a ready-made registry for patient management, and generates a high degree of physician engagement and support for public reports.

Many years ago, the reporting landscape was wide open. Health plans were not conducting surveys or requesting much quality data. However, through quality initiatives and the National Committee for Quality Assurance requirements, quality reporting flourished, and health plans began requesting quality data from hospitals. Massachusetts Health Quality Partners identified a need for coordinating and rationalizing requests from health plans regarding quality data, and hospitals identified value in the uniformity of forms, data definitions, measures, timelines, and processes for meeting demands the health plans were placing on them. In addition, physicians were receiving multiple statewide preventive care guides from numerous health plans. The Massachusetts coalition

consulted with health plans and developed one set of unanimously accepted guides to be sent to physicians. Both the physicians and health plans were grateful for this standardization. Being able to recognize the need for coordination, standardization, and rationalization was an effective strategy for creating value and should be considered when looking to create value for stakeholders within your own coalition.

Chapter 5. Building Trust

Trust is established when there is a perceived good-faith effort to behave in accordance with a group's commitments (i.e., delivering on what is promised). Several factors, such as shared social norms; repeated interactions; shared experiences; and reliable, consistent, and predictable leadership also have been suggested to facilitate the development of trust. Perhaps the most fundamental component of trust is the ability to communicate effectively, which involves much more than sharing information. Effective communication establishes an understanding between individuals and organizations.

The mutual respect that can lead to trust must come from this communicated understanding. Once a relationship has experienced mutual respect, it is possible for participants to experience enduring relational trust, which is a feeling that binds people together over time and through trials.

Trust among a diverse group of stakeholders is essential to building and maintaining a regional coalition. Perhaps the most daunting obstacle to this kind of open communication for coalitions is the traditionally competitive relationship among some stakeholders. It takes effective leadership skills to develop the honest communication and rapport that will help competitors see beyond their business interests to the larger social good that collaboration offers.

Competition Versus Collaboration

Competition may be healthy for the economy, but collaboration is necessary for value-driven health care to succeed. Coalition leaders need to foster a collaborative process that is open and inclusive and leads to a consensus among competitors. It is important for leaders to build trust by lowering traditional barriers. One barrier, in particular, is a reluctance to share data among stakeholders. Providers may see releasing pricing data as a disadvantage, and public ratings generate concerns among competing medical groups. Traditional tensions between physicians (i.e., medical associations) and health plans also can be an issue, such as when physicians question health plan motives.

Suggested processes for lowering competitive barriers among participants follow.

Appeal to the Greater Good

When talking to stakeholders who are reluctant to share data with competitors, emphasize that systemically improving health care quality in the community requires broad collaborative effort. Providing cost-effective, quality health care should be something on which everyone can agree to cooperate.

It is also important to emphasize that stakeholders working collaboratively are able to accomplish larger, more comprehensive data gathering and reporting than by working individually. Creating and sharing a larger, broader data set among a range of stakeholders is essential for significant health care system improvement.

Facilitate Candid Discussions

Coalition leaders should be ready to construct a coalition at a pace that will allow stakeholders to build trust. During the startup phase, the most important task is to find the common ground for all

parties. Facilitating frank discussions among physicians, plans, and employers in a neutral meeting space can ease participants' suspicions and let them find common ground. Beyond the startup phase, involve as many diverse participants as possible in overseeing coalition activities.

The Center for Health Information and Research, for example, upon the inception of Arizona HealthQuery, formed a regular data partner meeting that includes all regional coalition stakeholders. This process builds trust, establishes transparency, and promotes an environment in which sharing is possible. Similarly, Massachusetts Health Quality Partners developed its Physician Council as part of the governance structure to ensure all physician groups work together to influence the process.

Develop and Adhere to a Set of Shared Values

Several coalitions use a strategy to engage their members in the development of a set of shared values that will govern the coalition's work. For example, the Wisconsin Collaborative for Healthcare Quality has a code of ethics that emphasizes the importance of member adherence to standard measures, consistent timeframes and timelines for reporting, a willingness to share best practices, and a commitment not to use the performance results in marketing or other overtly competitive activities.

Tip: In discussions that precede enrollment of a stakeholder, offer direct, objective responses to all issues of concern. Do not evade issues or gloss over any problems raised.

Chapter 6. Funding and Sustainability

Securing funding is a key component of maintaining a vital regional coalition. In the beginning stages of a new coalition, the focus often is on identifying initial funding rather than long-term sustainability. Many funding sources are available, both private and public, that can help coalitions obtain the financial resources necessary to initiate a first project.

To build and sustain momentum, it is important to consider targeting private grant opportunities rather than State-funded resources, which can be more time consuming.

General traits that funders look for in grant applications include how well the project aligns with the request for proposal or the overall focus of funding, the applicant's capacity to accomplish goals (for example, staff size and structure), and a realistic budget closely related to the scope of the project.

Grant funding, in particular, is not seen as a reliable means of long-term development. Most of the six Better Quality Information sites rely on a combination of membership fees and grant funding to sustain the coalition. Additionally, the sites have arranged funding opportunities unique to their circumstances:

- The Center for Health Information and Research is supported by a mix of research contracts and grants for specific projects, funding from Arizona State University's Office of the Vice President of Research and Economic Affairs, and foundation grants.
- The California Cooperative Healthcare Reporting Initiative receives much of its funding for specific programs from fees paid by participating health plans and physician groups. Grants and funding from the Pacific Business Group on Health provide additional resources.
- For the first 3 years of the Minnesota Community Measurement coalition, health plans and the Minnesota Medical Association sponsored the bulk of the costs. In 2007, the coalition's funding included a mix of sponsor funding from the founding organizations, private grants, fee-for-service contracts, and federal contracts. The Minnesota Community Measurement board is developing a new long-term financing strategy.
- The Wisconsin Collaborative for Healthcare Quality is structured as a membership organization, and member dues are a primary source of funding to support the organization. The dues cover a significant percentage of the collaborative's core operating budget, with the balance supported by an unrestricted grant from a local foundation. In exchange for the dues, members receive access to coalition tools and measurement specifications, have their data reported through the Wisconsin Collaborative for Healthcare Quality Web site, and are eligible to serve on the board.

One of the challenges the Wisconsin collaborative currently faces is health care consolidation, which decreases the number of its members. For example, the collaborative recently lost four members to consolidation, reducing the base of its membership and revenue. Consequently, it will be evaluating options for restructuring its dues to include a model that tiers payments based on organizational size. This likely would have the added advantage of making membership in the Wisconsin collaborative more accessible to smaller physician office practices.

Although the short-term focus is important, a new coalition also can begin developing a sustainable business case that defines its enduring value to the community beyond individual projects. The Better Quality Information sites identified the following tips for developing a sustainable case:

- Assess your market and community. Make sure that you have a market for your services and that your services do not overlap with other community efforts. (See “Assess Your Regional Environment” in Chapter 3.)
- Identify your customers. Who will benefit from your services? What contribution can they make to the coalition? Be sure to involve in your process those customers who can make changes in the early development.
- Develop flexible services of unique value that will grow to fit your customers’ special long-term needs, such as the Indiana Health Information Exchange’s DOCS4DOCS® service (discussed below).

Special Services

Some sites have created special services that generate revenue to sustain coalition activities. Special services provide easy access to data in formats that make stakeholders more effective and efficient.

The Center for Health Information and Research, Massachusetts Health Quality Partners, and Indiana Health Information Exchange developed unique services for stakeholders in return for sharing data. For example, a unique service the Center for Health Information and Research provides stakeholders is the fulfillment of ad hoc requests. Data partners often have questions about their own data or the prevalence of a particular condition for patients in their system versus the community. The center is able to quickly respond to these types of questions and does so pro bono as a benefit of being an Arizona HealthQuery data partner.

Massachusetts Health Quality Partners offers to oversample for granular data that physician groups may want in addition to the standard data the coalition reports. This optional service may create additional value for stakeholders.

The Indiana Health Information Exchange started as a way to create value and marketable services for stakeholders, in contrast to the other Better Quality Information sites, which focused primarily on developing quality improvement support and public reporting and are just now moving toward developing value-added services for participants. The exchange’s DOCS4DOCS® service is an independent, community-based clinical messaging service that electronically delivers test results and other clinical information securely and effectively to physicians. The Quality Health FirstSM program is a clinical quality program for health and chronic disease management that provides physicians and health insurers with standardized quality measures. The program provides payers with physician scores to support a pay-for-performance incentive program as well as detailed measurement information for the payer’s enrollees.

The business model for Quality Health FirstSM is that payers pay a per-member, per-month fee to the Indiana Health Information Exchange to administer the program and agree to provide physicians an incentive based on participation and overall health improvement of their patient population. The most beneficial aspect of the exchange’s clinical messaging service is it engages providers by providing a valuable service and establishes shared goals in a nonthreatening way. Additionally, as DOCS4DOCS® has brought in more revenue, the Indiana Health Information Exchange’s leadership has been able to increase its staff and branch out across the State.

The Indiana Health Information Exchange has successfully worked with other groups in the country in replicating Indiana’s health information services. In Tennessee, for example, the Indianapolis Network for Patient Care model helped an informal group of stakeholders to grow into a fully running coalition within 3 years.

As the Indiana Health Information Exchange has pointed out, one potential drawback to this approach is that it does not build the same cohesion among stakeholders that other Better Quality Information sites have cultivated during the startup phase. The exchange primarily has concentrated on developing services in the Indianapolis area and, as it begins expanding across the State, may encounter challenges in getting buy-in for public reporting from statewide associations.

Tips for adapting the Indiana Health Information Exchange's data service model include:

- Develop data services in “baby steps” and make sure that they are adaptable to local communities and are self-sustaining (for example, clinical messaging).
- Focus services on regional needs, as different regions within a State can have very different needs and stakeholders.

Chapter 7. Governance

Governance involves setting direction, making policy and strategy decisions, overseeing and monitoring organizational performance, and ensuring overall accountability for a coalition. Effective governance is about making informed organizational policy choices, such as defining the coalition's mission and goals, determining how to achieve these objectives, defining what resources are necessary and how best to secure them, and determining how to measure the coalition's overall impact.

The governing board is composed of members from the various organizations participating in the coalition. It is important, therefore, that board members be committed to making unbiased decisions that represent broad constituent interests rather than the interests of their respective organizations. It is also important to be aware of potential conflicts of interest that board members may have. Such conflicts not only can create legal liabilities but also can damage public perception and disrupt trust among participants. As with all aspects of a regional coalition, transparency and collaborative processes are essential to governing a broad-based group of constituencies.

Although characterized by unique variations, the governing structures of each Better Quality Information site share common elements, such as an executive board or board of directors and assemblies. Additionally, each has subcommittees or workgroups that focus on specific issues like finance and development and make recommendations to the larger board for action.

A brief description of two basic components of coalition governance structures follows.

Executive Committee or Board of Directors

The executive committee or board of directors is the coalition's main leadership group responsible and accountable for its conduct and performance. This governance structure typically establishes policies and directs the growth of the coalition. Therefore, equal representation from key stakeholder groups, such health plans, provider organizations, government agencies, consumer representatives, and employers, is important.

Generally, representatives are expected to represent the interests of their stakeholder groups, not those of the individuals' particular organizations.

Assemblies

Within the governance structure, the Better Quality Information sites also have created group meetings in addition to the executive committee or board of directors.

The Wisconsin Collaborative for Healthcare Quality's board of directors, for example, is responsible for furthering the work of the coalition's Collaborative Assembly, which is primarily composed of chief executive officers, chief medical officers, and senior quality executives from each member institution. The assembly meets in Madison, Wisconsin, once a month for 10 months of the year.

The Center for Health Information and Research has regular data partner meetings for entities who contribute data to the Arizona HealthQuery data system the center houses. The meetings bring together all the data partners to discuss current and future initiatives. Because of the voluntary nature of the coalition, one goal of the data partner meetings is relationship building, but these

meetings also help to shape the direction of the coalition. Additionally, the center has an advisory committee to provide guidance in strategic planning efforts for the research center.

Massachusetts Health Quality Partners has established a Physicians Council so that, in addition to input from the Massachusetts Medical Society, the coalition also includes the perspective of the physician leaders of many of the physician organizations in the State. In addition to selecting representatives to participate on the coalition's board, the Physicians Council advises the Massachusetts Health Quality Partners on all aspects of its performance measurement and reporting agenda. The council meets quarterly and presents physician recommendations afterward at the board of directors meeting.

Chapter 8. Legal Issues

During a regional coalition's startup phase, legal issues usually are not the main focus as the coalition leaders recruit members and build relationships among stakeholders. As the coalition progresses, legal issues move more to the foreground and become more complex.

Contracting with participants can take much longer than originally anticipated because of negotiations with stakeholders and modifications to agreements. The larger an organization is, the more complex and lengthy the legal issues can be.

Coalition leaders need to be up front with stakeholders about their role in the coalition and how their data will be used. Establishing a data sharing policy that addresses who is involved, how the data will be used, liability issues, and so forth is helpful in clarifying the terms of agreement for participants. Because of the rapidly changing nature of the health care environment, it is also important to continually update the policy and be prepared to renegotiate legal agreements with each new project.

Examples of unexpected legal issues encountered by some of the Better Quality Information (BQI) sites follow.

- The Center for Health Information and Research found that, because lawyers for prospective data partners challenged aspects of the original agreements, the coalition needed to use more lawyers during the startup phase than initially anticipated.
- When the California Cooperative Healthcare Reporting Initiative asked health plans to contribute data for the BQI program, some of the health plans raised confidentiality issues as a legal concern, stating that some of their contracts with providers did not grant permission to share these data with the initiative.
- A major legal consideration for Minnesota Community Measurement arose early with regard to how health plans could collaborate on quality and not become entangled with antitrust issues. After the coalition became a nonprofit entity and other organizations, such as the Minnesota Medical Association and purchasers, became involved, the antitrust concern of health plans collaborating on quality efforts was no longer an issue. Nonetheless, the coalition suggests working with an antitrust attorney when creating a regional coalition.

Tip: Build in time up front to understand and address legal issues, such as data use and sharing and confidentiality agreements.

Chapter 9. Developing Metrics and Collecting Data

Developing Metrics

A metric is a standard measure for assessing performance in a particular area. Metrics are essential for any program directed at continuous improvement. Regional coalitions should develop metrics that cross hospitals, physicians, and employers. Doing so shows how stakeholders are interconnected and ensures compatibility of results.

In general, measures should be targeted to a specific area and collect accurate and complete data. A metric also should clearly convey performance in a timely and relevant manner. Regardless of what metrics a coalition settles on, the Better Quality Information (BQI) sites recommend carefully building consensus around a small number of measures (3 priorities versus 30) in the beginning. Once these measures are put into practice and trust among participants grows, coalitions can expand the number of metrics.

In its early stages, Massachusetts Health Quality Partners worked with a consultant who recommended that the coalition begin with measuring patient experience with hospital care. This idea appealed to participants because there was a clear path for collecting and using these data (for example, an instrument had been developed for collecting data, and scientific analysis had been established in interpreting data). Although not all clinicians were convinced that patient experience is an important part of quality care, Massachusetts Health Quality Partners saw the potential for an early success in this approach and recognized how well the public could relate to these data.

Collecting Data

Each BQI site has devised various approaches to data collection. Regardless of whether a coalition uses health plan claims data, Healthcare Effectiveness Data and Information Set (HEDIS) results, or data from physician practices, there are general issues that new coalitions need to consider. The Institute of Medicine has identified six challenges in collecting and reporting data that coalitions should expect:

1. Inefficiencies associated with performance measurement.
2. Variations among performance measurement systems.
3. Organizational and cultural issues.
4. Technological barriers.
5. Economic pressures.
6. Competing priorities.

Common questions for forming regional coalitions to consider involve data collection and analysis: Who is the primary customer for the data, physicians or consumers? What do you use the data for, quality improvement or leverage for change? Currently, the primary users of data reported by BQI sites are physicians who use data to make improvements in their care delivery. Only in the past couple years has the focus shifted to include consumer use. Many sites agree that, at this point, consumers are not interested in publicly reported data or they may not know how to use it. However, one of the consumer advocacy groups represented on Massachusetts Health Quality Partners' board developed a quality council to engage the public in determining the kind of information that is most useful for consumers.

Basic data issues that new coalitions need to address to reassure stakeholders and maintain trust follow.

Data Validity

Data validation is a systematic process for reviewing a body of data against a set of criteria to ensure the data are adequate for their intended use. Developing a data validation process early is important for participant buy-in and trust the process to be effective.

Data validation is an integral component of the Wisconsin Collaborative for Healthcare Quality's measurement model. The collaborative uses a Web-based data submission tool that allows participating medical groups to submit performance measure results for reporting through the collaborative's Web site. The data submission tools require the groups organize the administrative and clinical data files required for calculation of the collaborative's measures in a consistent format, facilitating the audit of data used to calculate the measures.

Careful checks determine whether the measurement specifications were applied by member organizations in a manner that would allow for the same results. Review of the data warehouse construction also ensures that data for inclusion have been pulled from all available and appropriate sources. Each organization within the Wisconsin collaborative must validate its denominator files for each data submission in the spring and fall. Additionally, members are randomly assigned numerator validations during each cycle, and they must supply the data files and programming code used to obtain the data results. Audits of the data are conducted randomly or as requested by the Wisconsin collaborative's board or business partners.

Minnesota Community Measurement has two levels of data validation due to its process of aggregating data from 10 different sources. The first validation level is at the health plan with the HEDIS validation required for accredited health plans. The second level is when the data come to the Minnesota coalition. At this point, each file is validated for accuracy and sent back to the data source with questions that cannot be answered easily.

Minnesota Community Measurement also has data submitted directly from medical groups. The coalition has an extensive guide that walks the medical group through each step of the process to pull the data. Members of the coalition staff are available to answer questions or make an on-site visit to the medical group to clarify the process and overcome barriers. The Minnesota coalition's policy requires a Minnesota Community Measurement staff member to certify the denominator of each measure at midprocess before the group moves forward with extracting the data from an electronic medical record or abstracting data from a paper record. Further, the coalition reserves the right to make an on-site visit to each medical group to validate each step of the process and certify that its process meets coalition requirements.

Transparent Data Collection Methods

The coalition's data collection methods must be transparent to the entity being reported on. When there is trust in the credibility of the data and results, medical groups are more likely to support publicly reporting their data.

At the Indiana Health Information Exchange, clinical data from labs, hospitals, transcription notes, and so forth are collected electronically from those institutions without requiring physical effort by physicians. The exchange gathers claims data from payers. Minimal, specific point-of-care data are gathered from physician offices through a variety of tools in an attempt to be as least

intrusive as possible to the physician's environment. The Indiana exchange does not pull data from manual patient files or require physician offices' staff to do so.

For tests performed in the office and when the results or procedures are not available through insurance claims or labs, data need to be collected for specific measures and forwarded to the Indiana exchange. These data can be extracted electronically from the physician's electronic medical record and can be faxed on scannable, optical character recognition forms; entered through a Web application by physician office staff; or faxed to the exchange for manual data entry. Labs that are not currently contracted with the Indiana Health Information Exchange to send data directly to the data aggregator (Regenstrief Institute) can send spreadsheets or other electronic files directly to the exchange.

Data Testing and Credibility

Because the Indiana Health Information Exchange uses medical claims, point-of-care data, and clinical data collected from hospitals, labs, radiology, and the RxHub National Patient Health Information Network™ (a network that provides secure access to more than 90 percent of people with commercial prescription coverage in the United States), the data are richer. The Indiana exchange bases scores on data found for all patients, not simply Medicare or commercial payers enrolled in the program. Scores are determined by evaluating results on all the physician's patients, including those who are uninsured, members of nonparticipating payers, etc. Because the coalition has access to hospitals, clinics, and labs in the area, it has access to many patients.

The Indiana exchange first tests reports internally and then tests them with its Measures Subcommittee, which consists of physicians and payer representatives. After this step, the coalition tests reports with physicians and physician groups and then tests them with its larger Measures Committee before moving to production.

Confidentiality

Creating internal safeguards for data and establishing confidentiality protocols before recruiting stakeholders also will enhance the coalition's credibility and build trust among stakeholders. All BQI sites ensure data are encrypted and require all stakeholders to sign confidentiality agreements. Members of the Wisconsin Collaborative for Healthcare Quality assign pseudo-medical record numbers to files submitted during the data validation process, guaranteeing the ability to cross-reference the patient files, if necessary. This step also protects patient confidentiality by containing any patient-identifiable piece of information remaining with the host organization. Minnesota Community Measurement's policy addresses data use, including health data collection and measurement specification, data confidentiality, data contributor participation, public reporting of data, and release of coalition data.

Data Concerns

Self-Promotion

Stakeholders often express concern that competitors in the coalition will use publicly reported data for marketing purposes (for example, “We’re rated number 1.”). Data-use agreements should address this concern by having participants agree not to use data results for self-promotion.

Low Rating

One particularly difficult aspect of reporting involves low ratings that make a participant look bad. The California Cooperative Healthcare Reporting Initiative facilitates participant forums to help address and resolve the issues underlying the accurate reporting of scores. During these forums, every participant is able to express his or her concerns, problems, and questions regarding the data and their impact. Coalitions should frame low ratings as opportunities for improvement rather than reacting punitively or viewing them as shameful.

Determining the Cut Point

If the cut points between high and low ratings are not carefully defined, one group can end up with three stars and another with two when in fact their performance is not significantly different. The California Cooperative Healthcare Reporting Initiative worked with its stakeholders and national analytic experts to define a methodology that addressed this issue.

Data Challenges

Data challenges in regional coalitions range from how to use the data to who “owns” the data. New coalition leaders need to be ready to address these concerns up front and use them as opportunities to increase transparency and improve the coalition’s credibility.

All BQI sites have developed processes to help resolve data concerns and challenges. Specific examples of data partner meetings follow.

Data Partner Meetings

The Center for Health Information and Research holds quarterly meetings to bring together all the data partners to discuss current and future initiatives. One goal of the meetings is to build relationships. The idea is that once relationships are built and maintained, the relationships will foster more collaboration and information sharing with the ultimate goal of improving community health in Arizona.

All Participants Meetings

The California Cooperative Healthcare Reporting Initiative holds biannual All-Participants Meetings where staff present results for the:

- HEDIS data collection project.

- Health Maintenance Organization Consumer Assessment of Healthcare Providers and Systems member survey.
- Patient assessment survey.
- Special studies.

During a HEDIS results presentation, for instance, the analyst identified quality improvement opportunities based on low rates, large variation across the California Cooperative Healthcare Reporting Initiative's plans, and poor performance compared to the National Committee for Quality Assurance 2006 national percentiles. For measures with rates below 60 percent, the analyst highlighted those that could potentially be improved through sharing best practices and others that indicate where an opportunity exists for all plans to improve.

Throughout each presentation, members of the group are encouraged to ask questions and raise concerns. At the meeting's end, participants are invited to provide thoughts on opportunities for improvement for particular measures.

Other Approaches

Physician Council

Massachusetts Health Quality Partners also has meetings similar to the Arizona and California coalitions, but it meets quarterly with the coalition's Physician Council and board (data partners are on one or both of these groups). The council consists of medical directors from a group of physician organizations across Massachusetts who have come together under coalition's umbrella. The Physician Council's top priority is guiding the Massachusetts Health Quality Partners in establishing a collective set of clinical and service quality improvement priorities that could best be accomplished through collaboration with other coalition health care stakeholders. Two members of the council sit on Massachusetts Health Quality Partners' board of directors.

In addition to the Physician Council meetings, Massachusetts Health Quality Partners has regular meetings with data partners and Physician Council committees, such as the BQI Rapid Response Team, on specific uses of the data it receives as well as on reporting formats and messages.

The Massachusetts coalition has established a process in which physicians review physician grouping data and final results through a secure, private Web site or on compact discs to correct grouping inaccuracies before public release. If physicians express concerns about the measures, their concerns are discussed with the Physician Council. Coalition staff and board members review Physician Council recommendations that a measure not go public. If all are in agreement, the measure is not made public. Not reporting questionable measures increases credibility that any data reported will be accurate.

“Road Show” Approach

Before its first public launch, Minnesota Community Measurement conducted a 30-city “road show” around Minnesota for coalition leaders to present data results to providers. During the tour, the Minnesota coalition was successful in defusing provider concerns by framing the launch as a way to improve the system, not as a way to punish or embarrass anyone.

In general, the Minnesota coalition's system of review and validation before public reporting allows for discussion and debate. The National Committee for Quality Assurance also has been involved with Minnesota Community Measurement since its inception and has helped with implementation, especially with the sampling methodology needed for hybrid measures.

Member Work Groups

The Wisconsin Collaborative for Healthcare Quality has benefited from the work of an ambulatory care specifications workgroup that has been in existence for more than 3 years. Meeting once a week through teleconference, the workgroup is a vivid example of the power of collaboration in devising innovative approaches to complex measurement issues. Composed of quality measurement and improvement professionals from the Wisconsin collaborative's member organizations, the workgroup is the source of the collaborative's distinctive "all patient, all payer" measurement methodology that focuses reporting at the population level for all eligible patients, regardless of source of payment. The ambulatory care specifications workgroup oversees the development and maintenance of measurement specifications, the cycle of data submission and reporting, and enhancements to the Web-based suite of measurement tools.

Chapter 10. Marketing

Early on, coalitions need to develop a communication and marketing plan that presents a consistent image of the coalition and uses clear and appropriate communications. This plan serves two purposes:

1. Internally, it is essential for building and maintaining trust among stakeholders. Apparent unresponsiveness, muddled messages, and ill-defined goals can quickly damage the coalition's reputation.
2. Externally, it shapes how the media and the public understand the role of the coalition and how to use performance data.

Among Stakeholders

Define Your Terms

Misperceptions among participants can be an issue when forming a coalition. Confusion can occur on the scale of the project and in the way participants understand the terms being discussed. The Wisconsin Collaborative for Healthcare Quality stressed the importance of defining terms to ensure precise language among the participants. In its experience, confusion and tension were at times caused by the different ways participants understood the terms “provider,” “cooperation,” and “collaboration.” In Wisconsin, physicians define themselves as clinicians, but health care systems define them as providers. Cooperation can denote a more informal relationship than collaboration, which requires a more durable, intentional agreement between two organizations to work together under a commonly defined mission and structure. It is crucial, therefore, to be clear in communicating objectives and defining terms with stakeholders.

Develop Communication Objectives for Each Stakeholder

The overall communication approach with stakeholders should be proactive, not reactive. It is important to develop particular messages for each core constituency and institute processes for regularly communicating with them.

Stakeholder audiences and key messages include:

- Employers, who look to provide employees information on where to get the best care. They also want to purchase value—the best quality care at the lowest cost.
- Consumers, who look for information to make care decisions about a provider or practitioner who fits their care needs.

Methods for Communication

Minnesota Community Measurement publishes a newsletter five to six times a year for the provider community. At open enrollment time, the coalition routinely connects with large employers in its market to offer information for employees and refreshes data annually posted to the Minnesota coalition's Web site. Additionally, the Minnesota coalition has a regular news media release that communicates annual results through a live Web cast to the provider community and consumers and encourages them to visit the coalition's Web site.

It is also important to engage stakeholders, particularly those being reported on, in a collaborative process that allows for open debate and generates buy-in on how data will be reported and framed, what the cut points should be, what labels should be used, and so forth.

The Indiana Health Information Exchange follows an extensive internal review process that determines what larger messages are developed for the public. The process involves conducting Administrative Committee meetings, Measures Committee meetings, and Measure Subcommittee meetings monthly and Action Team meetings biweekly. The Administrative Committee involves high-level employer, hospital, and physicians groups and is weighted heavily toward payers and employers. Among other functions, it reviews program status, discusses directional issues, and reviews budget recommendations. The Action Team is a lower-level, smaller team that represents the types of organizations represented on the Administrative Committee. The Action Team reviews, studies, and formulates recommendations around issues before they go to the Administrative Committee. The Measures Committee consists primarily of physicians and medical directors and discusses clinical issues, measures, physician issues, and so forth. The subcommittees (Quality Health First, General Measures, Cardiology, and Orthopedics) study details concerning specifications, impacts, and so forth, before taking information to the larger committee. The Indiana coalition's public relations staff works with local news agencies to communicate high-level progress and initiatives derived from this process to the general public. Additionally, the Quality Health First subcommittee conducts monthly program overview presentations with any interested constituencies.

The California Cooperative Healthcare Reporting Initiative conducts regular Project Committee conference calls. The committee is composed of project stakeholders and is charged with making project-specific recommendations to the Executive Committee. In addition, the California coalition conducts a monthly "all participant" conference call to provide stakeholders updates on each project. Stakeholder-specific calls are scheduled as the need arises.

Facilitate Frank and Open Discussion Among Participants

As part of the startup process, provide regular forums where members can discuss and debate strategies and concerns. Regular meetings of coalition leaders and stakeholders are a good way to keep everyone on task, update one another on progress, and determine what needs to be done by whom.

To this end, Minnesota Community Measurement has set up two formal advisory groups. The Reporting Advisory Committee sets reporting policy, and the Data Planning Committee establishes the details around measurement. The Reporting Advisory Committee is composed of crucial stakeholders, including medical groups and health plans, and makes recommendations to the Minnesota coalition's board on what measures Minnesota Community Measurement will report and how it will display the quality information. The Data Planning Committee comprises all the health plans in Minnesota that submit data to the coalition and advises on data collection and aggregation.

Types of Communication

Internet/Intranet

Establishing an Internet presence is important for creating and promoting your coalition's public identity. The coalition's Web site often will be the first place people will go to learn about its

mission and activities. Each Better Quality Information site has a Web site that includes an overview of the coalition, its partners, governance structure, and contact information. Some also include press releases of significant developments, guidelines, performance reports, tools, publications (for example, reports), and links. Links to the Web sites follow.

- Center for Health Information and Research-Arizona State University—<http://chir.asu.edu>.
- California Cooperative Healthcare Reporting Initiative—<http://www.cchri.org>.
- Massachusetts Health Quality Partners—<http://www.mhqp.org>.
- Minnesota Community Measurement—<http://www.mnhealthcare.org>.
- Indiana Health Information Exchange—<http://www.ihie.com>.
- Wisconsin Collaborative for Healthcare Quality—<http://www.wchq.org>.

Coalitions establishing an Internet presence should work with an information technology partner that is engaged with the coalition and sensitive to the needs of the health care community and a collaborative project.

Once the Web site is available, tracking traffic to the site is useful in understanding what constituencies are visiting and how often. Placing links to your site on stakeholder Web sites is an effective way to track visitors from that particular group.

A key tool for coalitions is a reliable and effective Intranet. The Wisconsin Collaborative for Healthcare Quality, for example, uses its Intranet for providers to review data before reporting it publicly on its Web site.

Newsletters and Presentations

An effective way to promote coalition activities is to publish an e-newsletter. For example, Minnesota Community Measurement's e-newsletter is *The Measurement Minute*. (For an example, click on http://mnhealthcare.org/News/2006-05/MNCM_eNewsletter_2006-05.html.)

It may be challenging to produce content and manage a subscriber list; however, additional cost-effective ways to promote the coalition exist. These include contributing articles about coalition activities to stakeholder newsletters and giving presentations at stakeholder conferences.

Create a “Genesis Story”

Develop a narrative that tells what your coalition is, what it does, how it began, and what its early processes and successes were. This method is excellent for introducing the coalition to the media, legislators, stakeholders, and the public.

Public Relations and News Media

Establishing a coalition entails marketing what the coalition does. Working with the media can be an effective avenue for promoting positive news about the coalition and attracting potential collaborators and partners. In the formative stages, many Better Quality Information sites deliberately chose to maintain low profiles because they did not want “the hype to get ahead of reality.” They wanted all aspects of the coalition to be on solid ground before developing marketing and public relations strategies.

Still, developing an effective public relations approach early on is crucial to maintaining a regional coalition, particularly when dealing with the news media. One approach is to cultivate relationships with health writers and reporters in the local media and provide them with background on the data and what the data mean. This will ensure providers are not misrepresented in the press.

Potential negative outcomes can contribute to providers' reluctance to participating in public reporting. Coalitions need to be sensitive to the effect release of data will have on the public. If not framed correctly and understandably, data can damage public perception of providers, even if the physicians are doing a good job.

Positive Influence

Massachusetts Health Quality Partners has established relationships with local media to ensure accurate accounting of the complex issues behind public reporting of data. In one instance, a newspaper was going to publish an article about the Massachusetts coalition's patient experience reporting that misleadingly expanded cut points from three to seven. Because of the relationship between the newspaper and Massachusetts Health Quality Partners, the editor showed the coalition what it intended to print before publishing the article. The coalition explained why the established cut points were crucial for accuracy, and this was reflected in the published article.

Tips:

- If your budget allows, work with communications experts (including public relations professionals from stakeholder organizations) to develop ways to educate the press and identify key words and messages that everyone in the coalition can use when communicating with the press and the public.
- It is not easy to explain to members of the media and the public where data come from and what they ultimately mean. Take time to develop a clear, understandable message.
- Before a new launch of data, develop and provide talking points to stakeholders that help them explain results to the news media.
- When stakeholders join the coalition, make certain they know that part of their responsibility as members includes promoting the coalition.
- An important part of branding the coalition involves having a high-profile executive director who participates in face-to-face meetings with constituents to drum up interest and recognition.
- To ensure a consistent message, establish a policy that requires all documents containing data produced by stakeholders be reviewed and approved by the coalition before submission.

Chapter 11. Measuring Success

An integral part of quality improvement is measuring the impact of improvement activities. Doing so demonstrates whether you are moving toward your vision and accomplishing your priorities. At this time, the six Better Quality Information sites do not have formalized measures for determining their success. However, they do use informal methods of gauging stakeholder satisfaction and measuring the coalition's effectiveness.

Massachusetts Health Quality Partners, for instance, measures its success in how many stakeholders want to continue participating in the coalition. In addition, the Massachusetts coalition has anecdotal information from the physician community on how it uses the coalition's data to encourage physicians or to create improvement projects. Consequently, one network has included a session in its annual meeting on how to improve the coalition's reports. The amount of positive press coverage the coalition receives and the number of press releases the media pick up also validate that people are paying attention to the Massachusetts Health Quality Partners' work.

The Massachusetts coalition also measures success through the amount of research funding it receives from outside the State and brand recognition, which is calculated by how many people know what "Massachusetts Health Quality Partners" or "MHQP" is and what it does. Finally, the coalition has research efforts underway to understand how practices use aspects of its data.

For the Center for Health Information and Research, because it is an academic research group, it measures success in funding secured through grants and contracts for service, its delivery of community reports to the Arizona community, and scholarly publications.

Chapter 12. Improvement Support

Often stakeholders are uneasy about the effect negative data will have on them. Providing participants with tools and resources for improving low ratings is an important aspect of measuring and reporting data. Without this component, measures can appear punitive to stakeholders and may discourage participation.

As the following three examples indicate, some Better Quality Information sites focus exclusively on data collection, analysis, and reporting. Other sites partner with quality improvement groups that use the data to help stakeholders develop and implement quality improvement methods.

- The California Cooperative Healthcare Reporting Initiative, founded and now partners with the California Quality Collaborative to work with physician groups and health plans to share lessons learned, conduct performance improvement projects, and provide other quality improvement services.
- Massachusetts Health Quality Partners works with the Massachusetts Quality Improvement Organization and the Massachusetts Medical Society to develop a quality improvement curriculum. Using the coalition's data, the curriculum will integrate improvements in clinical quality with improvements in patient experience.
- The Wisconsin Collaborative for Healthcare Quality shares data with organizations before public release and invites the organization to add an addendum to the collaborative's announcement about how the information will affect the organization. The Wisconsin collaborative then sponsors educational sessions and activities as a means of sharing best practices to help drive improvement. In addition, the Wisconsin Collaborative for Healthcare Quality's Cardiac Collaborative consists of seven organizations that have voluntarily come together to drive improvement in both the quality and cost of revascularization services in their institutions.
- The Center for Health Information and Research uses the principle of prior approval by potentially identified data partners on all proposed research using Arizona HealthQuery data, but no data partner has control over results once approval is granted.

Whichever emphasis a new coalition wants to have, it is important to decide early whether it will be reporting driven or improvement driven. This decision will help to clarify the coalition's ultimate mission and identify organizations that can help assist with quality improvement (for example, Quality Improvement Organizations).

Appendix A: BQI Pilot Site Overview

	Center for Health Information and Research-Arizona State University	California Cooperative Healthcare Reporting Initiative	Indiana Health Information Exchange	Massachusetts Health Quality Partners	Minnesota Community Measurement	Wisconsin Collaborative for Healthcare Quality
Founding Date	1995 ¹	1993	2004	1995	2002	2002
Aim	To provide all health care stakeholders information that enables quality improvement activities at the policy and the practice levels.	<ul style="list-style-type: none"> •To collect and report standardized, reliable health plan, and provider performance data. •To promote the use of accurate and comparable quality measures within health care. •To create efficiency in data collection, leading to reduced burden and cost to all participants. •To provide a source for expert advice to consumer reporting entities. 	<ul style="list-style-type: none"> •To use information technology and shared clinical information. •To improve the quality, safety, and efficiency of health care in the State of Indiana. •To create unparalleled research capabilities for health researchers. •To exhibit a successful model of health information exchange for the rest of the country. 	To improve the quality of health care services delivered to the residents of Massachusetts through broad-based collaboration among health care stakeholders.	To accelerate the improvement of health by publicly reporting health care information.	To improve the quality of health care in the State of Wisconsin through the development and public reporting of a comprehensive range of health care performance measures.
Collaborative Composition	Arizona providers, employers, health plans, a State university, and a community health organization	Health care purchasers, plans, and providers	Institutions representing hospitals, providers, researchers, public health organizations, and economic development	Physicians, hospitals, health plans, consumers, purchasers, and government agencies	Health plans, medical groups, physicians, patients, employers, and others	Physician groups, hospitals, health plans, integrated delivery systems, and business partners/purchasers

	Center for Health Information and Research-Arizona State University	California Cooperative Healthcare Reporting Initiative	Indiana Health Information Exchange	Massachusetts Health Quality Partners	Minnesota Community Measurement	Wisconsin Collaborative for Healthcare Quality
			groups			
Community Definition	Maricopa County, Arizona, which has roughly 60% of the State's population	The State of California	Nine-county Indianapolis metropolitan statistical area, accounting for 26% of the State's population	The Commonwealth of Massachusetts	Report on over 100 primary provider groups, representing 700 clinics in Minnesota and bordering counties, covering roughly 90% of primary care delivered in the State. Beginning to report on specialty medical groups. Data sources include eight health plans and two county-based purchasing organizations.	Individual clinics that make up the health systems in the collaborative, representing roughly 40% of the licensed physicians in Wisconsin
Implementation of Physician Performance Improvement Efforts	Planned	1997	2004	2003	2002	2004
Public Reporting Launch	Currently not publicly reporting	1994	Pilot testing in 2006	1995	2004	2003
Public Reporting Level	Not applicable	Health plan level Physician group level for patient assessment survey results	Not applicable	Hospital level in 1998 Physician network in 2005 Medical group level for patient experience survey results in 2006	Medical group and on two measures at clinic site level	Physician group
Current Reporting	Not applicable	Annual	Monthly	Annual	Annual	Annual

	Center for Health Information and Research-Arizona State University	California Cooperative Healthcare Reporting Initiative	Indiana Health Information Exchange	Massachusetts Health Quality Partners	Minnesota Community Measurement	Wisconsin Collaborative for Healthcare Quality
Frequency						

¹ Arizona HealthQuery is not synonymous with St. Luke's Health Initiatives. Arizona HealthQuery began with funding from the Flinn Foundation, St. Luke's Health Initiatives' funding began approximately 4 years later.

Appendix B: BQI Pilot Profiles

California Cooperative Healthcare Reporting Initiative San Francisco, California

Mission

The California Cooperative Healthcare Reporting Initiative was convened to help consumers and employers make informed health care purchasing decisions through its mission to collect and report comparable, reliable performance data.

Overview

As a collaborative of health care purchasers, plans, and providers managed by the Pacific Business Group on Health, the California Cooperative Healthcare Reporting Initiative seeks to:

- Collect and report standardized, reliable health plan and provider performance data.
- Promote the use of accurate and comparable quality measures within health care.
- Create efficiency in data collection, leading to reduced burden and cost to all participants.
- Provide a source for expert advice to consumer reporting entities.

Convened in 1993 by the Pacific Business Group on Health, the California Cooperative Healthcare Reporting Initiative is governed by an executive committee with equal representation from purchasers, plans, and providers that oversees all projects and determines overall policy and strategy. A reporting committee advises the executive committee on all matters of internal and public reporting, whereas various project committees ensure that overall requirements and objectives of the projects are achieved. California Cooperative Healthcare Reporting Initiative stakeholders include Pacific Business Group on Health participating employers, representing nearly 3 million California employees, retirees, and their families; the major California health plans; and provider organizations.

Data Experience

The California Cooperative Healthcare Reporting Initiative has more than 10 years of experience collecting and pooling performance data at the health plan and medical group levels and, more recently, at the physician level. Eight health plans representing more than 85 percent of the commercial health maintenance organization population in California participate in a variety of the cooperative's data collection projects, and many plans participate in several different projects. In 2003, the Pacific Business Group on Health started collecting individual physician-level patient experience data and reporting performance feedback results to providers from 12 groups. In 2006, the California cooperative reported results from more than 3,000 individual physicians from 27 groups.

Performance Measurement

Since 1997 the California Cooperative Healthcare Reporting Initiative has advanced physician-level performance measurement in California and is currently using a survey tool based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey tool in physician-level measurement. The cooperative's work in California has informed the CAHPS survey development process. In particular, the cooperative and Pacific Business Group on Health staff have actively worked to develop the CAHPS as part of an effort to create a nationally standardized tool for measuring patient experience at the group, physician, and practice-site levels.

Reporting and Performance Improvement

The California Cooperative Healthcare Reporting Initiative has issued annual performance feedback reports since 1994. These reports, conducted through multiple reporting vehicles, compare the performance of the participating health plans on specific measures. Physicians receive feedback reports by individual health plan members of the cooperative and their respective medical groups. The cooperative's *2005 Report on Quality* included results for each participating plan as compared to the national mean, national 75th percentile, and national 90th percentile, for the following clinical topics:

Chronic Care

Diabetes care
Asthma care
Antidepressant medication
Mental illness
High blood pressure treatment
Beta blocker treatment
Cholesterol management
Appropriate treatment for children with upper respiratory infection
Appropriate testing for children with pharyngitis
Osteoporosis

Preventive

Immunizations for children and teens
Prenatal care
Postpartum care
Breast and cervical cancer screening
Chlamydia
Colorectal cancer screening
Smoking cessation
Influenza immunizations

Impact and Accomplishments

- The California Cooperative Healthcare Reporting Initiative is the main source of data for California's Office of the Public Advocate consumer report card, the official health plan and medical group report card for the State.
- Employers, such as CalPERS and Wells Fargo, use the cooperative's data in their plan chooser tools for employees and their dependents.
- The California Cooperative Healthcare Reporting Initiative produces physician group performance data that are used by Integrated Healthcare Association pay for performance.
- The California Cooperative Healthcare Reporting Initiative spawned a multistakeholder quality improvement collaborative, the California Quality Collaborative, whose mission

is to advance the quality and efficiency of patient care in California through collaboration.

- The Pacific Business Group on Health has been actively involved in the Agency for Healthcare Research and Quality-funded CAHPS development work to create a nationally standardized tool for measuring patient experience with care at the group, physician, and practice-site levels.

Center for Health Information and Research-Arizona State University Phoenix, Arizona

Mission

The Center for Health Information and Research provides all health care stakeholders with information that enables quality improvement activities at the policy and the practice level.

Overview

The Center for Health Information and Research is an academic-based research group at Arizona State University that is the home of Arizona HealthQuery, a community health data system. This data system, a voluntary collaboration of health care providers, insurers, employers, and a variety of State entities, offers a comprehensive view of the relative performance of all stakeholders in advancing quality, efficiency, effectiveness, and productivity. Arizona HealthQuery, a patient-centric dataset, offers the unique ability to track patients across time, providers, and payers.

As a collaborative venture, the center promotes a consensus-based approach with robust input, communication, and outreach to the provider community. From the beginning, physician and hospital leaders have actively participated in the effort, with partners pledging to use quality, outcome, and value measures to expand the existing Arizona HealthQuery database.

Data Experience

The aim of the Arizona HealthQuery project is to develop and maintain a community health data system that houses essential and comprehensive health information for each resident of Arizona. The system is unique for its ability to provide continuously updated health care information and to link patients across systems and over time. The Arizona HealthQuery database began in the early 1990s, has been in production in its current form since 2003, and currently integrates data from a large number of data sources.

Performance Measurement

In 2007, the Center for Health Information and Research began reporting measures related to breast, colorectal, and cervical cancer screening as well as to coronary artery disease. It plans to expand its measures related to heart failure, diabetes, asthma, and depression.

Reporting and Performance Improvement

Many studies have been conducted using the Arizona HealthQuery data warehouse. Most recently, *The Effect of AHCCCS Disenrollment on Health Care Utilization in Maricopa County* found that enrollment in the Arizona Health Care Cost Containment System, or AHCCCS, was associated with decreased emergency department use and decreased hospitalization as enrollees received more care through routine visits. The report also found that the decision to change eligibility and to disenroll members produces the opposite effect: more emergency department use, more hospitalizations, and less routine care.

In the first phase of the AQA* pilot, Center for Health Information and Research reports will be based on the performance of primary care physicians in Maricopa County, which represents about 60 percent of Arizona's population, according to 2004 U.S. Census population estimates.

Impact and Accomplishments

- The Center for Health Information and Research has robust health plan participation, including those actively involved in the AQA (for example, Health Net of Arizona, CIGNA, Humana, and PacifiCare), enabling natural synergies with AQA activities.
- Engagement of employer support has been cultivated. Employer support is driven by the Human Resources Policy Association, a national organization of 260 chief human resource officers representing the Nation's largest employers. The center's current employer partners include the Honeywell Corporation and the State of Arizona.
- The Center for Health Information and Research and Arizona HealthQuery have an established track record in data aggregation and reporting at the community level, offering a strong platform on which to build a broader data aggregation, public reporting, and quality improvement agenda. The existing database already includes administrative and encounter data for more than 9 million patients, including statewide Medicaid claims data.

* Formerly the Ambulatory Care Quality Alliance, this organization is now known simply as AQA because its mission was broadened to incorporate all areas of physician practice. (www.aqaalliance.org).

Indiana Health Information Exchange

Indianapolis, Indiana

Mission

The Indiana Health Information Exchange is committed to using information technology and shared clinical information to improve health care in Indiana, enhance health research, and be a national model of health information exchange.

Overview

The Indiana Health Information Exchange is a nonprofit venture supported by a collaboration of Indiana health care institutions. Its vision is to use information technology and shared clinical information to:

- Improve the quality, safety, and efficiency of health care in the State of Indiana.
- Create unparalleled research capabilities for health researchers.
- Exhibit a successful model of health information exchange for the rest of the country.

The Indiana Health Information Exchange was founded in 2004 by a collaboration of 13 institutions representing hospitals, providers, researchers, public health organizations, and economic development groups. The Regenstrief Institute, BioCrossroads, and the five charter hospital systems are key stakeholders. Other stakeholders include local and State health departments, the State medical society, community health networks, the local quality improvement organization, and the Employers' Forum of Indiana.

Data Experience

The Indiana Health Information Exchange covers a nine-county Indianapolis metropolitan statistical area in central Indiana. Physicians participating in the exchange cover roughly 60 percent of the fee-for-service population (mostly self-insured employers), 16 percent of the uninsured, 12 percent of the Medicare fee-for-service population, and 12 percent of the managed care population. The Indiana Health Information Exchange's data aggregation efforts are built upon those of the Indiana Network for Patient Care, the oldest, largest, and most successful health information exchange.

Through the initiative with Indiana Network for Patient Care, the exchange aggregates clinical data from several different sources, including hospitals, laboratories, and public health agencies. These data are then complemented with claims data from payers for the exchange's pay-for-performance project.

Performance Measurement

A consensus of medical directors from primary care practice groups and health plans determined the measures used to start the pay-for-performance program. The Indiana Health Information Exchange drew from established nationally accepted measures, such as those developed by the

AQA, the Centers for Medicare & Medicaid Service's Doctor's Office Quality Information Technology program, and the Healthcare Effectiveness Data and Information Set.

The criteria for choosing measures include national acceptability, clinical validity, relevance to payers and consumers, likelihood for improvement, and ability to measure outcomes. As the measures are finalized, the AQA's "Parameters for Selecting Ambulatory Care Performance Measures" will be used as a guideline.

Reporting and Performance Improvement

The Indiana Health Information Exchange's first milestone accomplishment is a community-wide clinical messaging service providing physicians with a single source for clinical results for laboratory and pathology, radiology, electrocardiogram reports, transcriptions, and emergency department and hospital encounter information from all participating central Indiana hospitals. The exchange will report to providers and consumers, with provider reports including summaries of provider performance on the included measures as well as individual patient-level reminders. Consumer reports will include physician group and community-level data.

Impact and Accomplishments

- The Indiana Health Information Exchange's stakeholder and partner, the Regenstrief Institute, is an internationally recognized informatics and health care research organization. Regenstrief's research scientists have developed the Regenstrief Medical Records System, one of the nation's first electronic medical record systems. Bridges to Excellence citations from investigators at the Regenstrief Institute account for approximately one third of Bridges to Excellence evidence.
- The exchange collaborates with the Indianapolis Patient Safety Coalition to address several important patient safety issues in the inpatient setting.
- The Indiana Health Information Exchange participates in nationwide knowledge-sharing efforts, such as Connecting Communities for Better Health.

Massachusetts Health Quality Partners Boston, Massachusetts

Mission

Massachusetts Health Quality Partners improves the quality of health care services to the residents of Massachusetts through broad-based collaboration among health care stakeholders.

Overview

Massachusetts Health Quality Partners was established in 1995 by Massachusetts health care leaders who recognized the importance of valid, comparable measures to drive improvement. As a coalition of physicians, hospitals, health plans, consumers, purchasers, and government agencies working together to promote improvement in the quality of health care services, the coalition provides physicians and consumers with comparative performance information on physician groups and practices. The coalition brings together a large number of Massachusetts health care organizations, including the State's Executive Office of Health and Human Services, its medical society, hospital association, physician leaders, and several major health plans, all of which collaborate to endorse and disseminate a variety of evidence-based practice guidelines and quality improvement tools.

Data Experience

Massachusetts Health Quality Partners has been aggregating physician-level data for primary care physicians across health plans since 2003. The coalition has reported on the comparative performance of primary care physicians on both Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience measures.

The Massachusetts coalition has developed a unique algorithm to group each individual physician into the appropriate practice site, medical group, and physician network. This allows Massachusetts Health Quality Partners to aggregate and report data at various levels of care from individual physician practices to physicians' offices, medical groups, and networks.

The coalition's data reporting covers roughly 5,000 adult and pediatric primary care physicians in five health plans serving commercially insured enrollees in health maintenance organizations and point-of-service products. More than 50 percent of commercially insured residents were enrolled in these plans during the period covered by the most recent report.

Performance Measurement

Massachusetts Health Quality Partners' online report, *Quality Insights: Health Care Performance in Massachusetts*, presents both clinical performance measures and patient experience measures. The clinical measures are drawn from the HEDIS Measure Set developed by the National Committee for Quality Assurance.

Patient experience measures are fielded from a survey instrument comprised of the best performing items from two validated surveys, Ambulatory Care Experiences Survey and the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey. The

instrument covers domains characterizing patients' experiences with their primary care physicians, including quality of physician-patient interactions and organizational features of care.

To further analyze performance measures and quality metrics, Massachusetts Health Quality Partners has forged partnerships with Tufts New England Medical Center, Massachusetts eHealth Collaborative, Harvard Medical School and Harvard School of Public Health, and the RAND Corporation.

Reporting and Performance Improvement

Massachusetts Health Quality Partners completed four cycles (2003–2006) of comparative HEDIS clinical performance reports to physician groups in Massachusetts, encompassing 2001 to 2006. In February 2005, the Massachusetts coalition issued its first public comparative performance report of 9 physician networks for 16 measures, including preventive care and management of certain chronic diseases. In February 2006, Massachusetts Health Quality Partners publicly released HEDIS clinical results for 150 medical groups. Performance stars are assigned to each group based on the group's performance against three benchmarks: the national 50th percentile, the national 90th percentile, and the Massachusetts statewide rate.

The current report includes the following HEDIS measures:

Chronic Care Measures

Asthma medication for children and adults
Cholesterol screening after a heart attack
Depression in adults
Diabetes care for adults

Preventive Measures

Well visits for infants, children,
and adolescents
Breast cancer screening
Cervical cancer screening
Chlamydia screening

In March 2006, Massachusetts Health Quality Partners publicly launched results from its first statewide survey of patient experience. The reports present results for more than 400 practice sites. Performance stars for patient experience reporting tells how a physician's office compares to all the other physicians' offices in the State that were part of the coalition's survey.

The current report includes the following patient experience measures:

Quality of Physician-Patient Interactions

Communication
Integration of care
Knowledge of the patient
Health promotion

Organizational Features of Care

Organizational access
Visit-based continuity
Clinical team
Office staff

Impact and Accomplishments

- For more than 10 years, Massachusetts Health Quality Partners has brought together multiple stakeholders, often with disparate agendas, who have effectively worked together to produce trusted, comparable performance measures that help drive health care quality improvement in Massachusetts.
- Massachusetts Health Quality Partners has successfully implemented five public releases of performance information: four with physician performance information and one with

hospital performance information. The coalition has designed a user-friendly Web site vetted by a health literacy specialist. The site incorporates findings from consumer focus groups the Massachusetts coalition has conducted to make information accessible and useful. Massachusetts Health Quality Partners has also developed a process to vet the public report and the press release with the coalition's multistakeholder members.

- Massachusetts Health Quality Partners has developed a Web-based reporting process to provide physician organizations with performance reports. The coalition reports annually to primary care physicians about performance on clinical HEDIS measures at the physician network, medical group, practice site, and, if requested by the medical group, at the individual physician level. The Massachusetts coalition reports to primary care physicians and, beginning in 2008, will report to cardiologists, orthopedists and obstetricians/gynecologists about performance on the patient experience survey.
- Massachusetts Health Quality Partners has successfully aggregated health plan claims data and attributed commercial health maintenance organization, point of service, and preferred provider organization patients to primary care and specialist physicians using a visit-based methodology to assign patients. It is the first organization in the country to implement this methodology, which enables it to broaden the patient experience survey to include preferred provider organization members and patients seeing specialists. The physician support and buy-in Massachusetts Health Quality Partners has garnered through its collaborative process means that physicians are more likely to embrace the measures resulting from this process.
- The Massachusetts eHealth Collaborative selected Massachusetts Health Quality Partners, in partnership with Computer Sciences Corporation, to pioneer efforts to capture data from electronic health records and translate them into clinical performance measures for use in comparative performance reporting for physicians. The collaborative brings together the State's major health care stakeholders to establish an electronic health record system that enhances quality, efficiency, and safety for health care in Massachusetts.
- Massachusetts Health Quality Partners is a founding member of the Network for Regional Healthcare Improvement, an association of regional health improvement collaboratives from around the country.
- Supported by Agency for Healthcare Research and Quality, Massachusetts Health Quality Partners is providing data to Harvard researchers to analyze the impact of electronic health records on clinical quality.

Minnesota Community Measurement St. Paul, Minnesota

Mission

Minnesota Community Measurement accelerates the improvement of health by publicly reporting health care information.

Overview

Since 2002, Minnesota Community Measurement's collaborative, community approach has encouraged medical groups to improve health care quality by publicly reporting on several measures. All seven of Minnesota's nonprofit health insurance plans participated in developing the coalition's initial reports, with the Minnesota Medical Association joining the effort in 2005. Since that initial report publication, a health plan in South Dakota and two county-based purchasing organizations have provided data to Minnesota Community Measurement.

The resulting nonprofit community-based organization has a 16-member board of directors, with representation from health plans, hospitals, physicians, employers, business groups, and consumer organizations. The Reporting Advisory Committee (consisting of physicians and health care quality improvement experts) advises the board on the scope of data and measures. A separate workgroup of data experts from health plans looks at technical issues around data and reporting.

Data Experience

Minnesota Community Measurement data reporting covers more than 100 provider groups representing 700 clinic sites in Minnesota and bordering counties. These groups cover roughly 90 percent of primary care delivered in the State. Minnesota Community Measurement has aggregated data across eight health plans and two county-based purchasing organizations, including commercial health maintenance organizations, point of service organizations, preferred provider organizations, Medicaid and State Children's Health Insurance Program managed care, Medicare Advantage, Medicare Cost, and Medicare dual eligibles.

The Minnesota coalition reports all measures at the community and medical group levels and is committed to adopting and incorporating nationally accepted standards. Presently, the coalition is working with eight health plans as well as with several of the Bridges to Excellence program's health information networks to obtain additional data. These data are submitted directly to Minnesota Community Measurement from the medical groups and posted on the coalition's Web site at the clinic-site level.

Performance Measurement

The Minnesota Community Measurement 2005 report assessed 10 clinical topics and included more than 40 individual measures. Measures include a composite measure for optimal diabetes care. This composite measures patients who have met all five treatment targets to decrease their risk of developing cardiovascular disease and other complications of diabetes. The coalition uses physician-defined standards of care endorsed by the Institute for Clinical Systems Improvement.

Reporting and Performance Improvement

Since 2003, Minnesota Community Measurement has been reporting on medical groups, with its first public report released in 2004. The coalition's 2005 Health Care Quality Report, based on calendar year 2004 data, compared each medical group against a State benchmark as well as against all other medical groups. The report included the following measures:

Chronic Care Measures

Optimal diabetes care composite (overall diabetes care)
Use of effective medications for asthma
Depression medication management
High blood pressure treatment

Preventive Measures

Immunizations for children and teens
Well-baby visits
Breast and cervical cancer screening
Chlamydia screening

New measures that were approved for reporting in 2006 (calendar year 2005 data) include:

Chronic Care Measures

Cardiovascular disease care composite
Appropriate treatment for children with upper respiratory infection
Appropriate testing for children with pharyngitis

Preventive Measures

Colorectal cancer screening
Cancer screening composite

Impact and Accomplishments

Minnesota Community Measurement is uniquely situated to rapidly implement data aggregation and reporting on new measures and to demonstrate the impact these efforts can have on improving the health of the community. Key accomplishments and impact on Minnesota's health care system include:

- Providing performance information that encompasses roughly 90 percent of primary care delivered in the State.
- Being one of the first organizations in the country to publicly report community-wide health care measure results by medical group.
- Having strong physician support as a cornerstone of success, as evidenced by physician board representation and leadership roles in advisory groups.
- Having as founding members all licensed Minnesota health plans that continue to provide direct financial support as well as a significant level of in-kind support through data collection and reporting.
- Participating with the Minnesota Business Partnership on developing cost-of-care measures.
- Collaborating with the State's Department of Human Services to develop a useful data collection and reporting process and tool for the State's Medicaid program.
- Operating a Web site for 2 years that provides consumer information on medical groups across the State, with the site receiving an estimated 30,000 visits in November 2005.
- Compiling evidence that overall community rates, including all children's health measures, are improving in Minnesota.

Wisconsin Collaborative for Healthcare Quality Madison, Wisconsin

Mission

The Wisconsin Collaborative for Healthcare Quality is a voluntary consortium of organizations learning and working together to improve the quality and cost-effectiveness of health care for the people of Wisconsin.

Overview

The nonprofit, statewide collaborative was founded in 2002 by several health delivery systems, each with a large multispecialty group clinic and tertiary hospital. Encompassing five geographically distinct markets, the collaborative now includes more than 40 physician groups, hospitals, and health plans, including two of the State's largest integrated delivery systems.

The Wisconsin Collaborative for Healthcare Quality is governed by a board of directors and funded by member dues and grants. It has the active support and participation of the clinical and administrative leadership of most of Wisconsin's large, multispecialty groups, representing approximately 42 percent of the licensed physicians in the State. With more than 40 reporting entities from virtually every region in the State, the Wisconsin collaborative actively solicits the participation of public and private sector purchasers in its work, ensuring consumer perspective is considered in selecting measures and the preparing the public report.

Data Experience

Although membership includes several health plans and hospitals, the Wisconsin collaborative's primary focus is measuring and reporting on physician groups. Members have tested and verified reliable methods of data collection and aggregation within a broad range of physician group practices. The measurement methodology emphasizes the specification of a denominator that is population based, representing "all patients, all payers" for a given condition. This method of reporting generates highly accurate and actionable information, which in turn has generated a high degree of support for the collaborative within the physician community in Wisconsin.

Performance Measurement

The Wisconsin Collaborative for Healthcare Quality has extensive experience in performance measurement at the physician-group level. Over the past 2 years, quality specialists from the collaborative's organizations have developed ambulatory care specifications that join administrative data with more robust clinical results, enabling health systems to collect and report quality of care results on all patients under their care. The collaborative's system and method measure the quality of care administered by health care providers on a given patient population. This approach offers several valuable outcomes, including the following:

- It provides a system view of performance with the ability to drill down to provider level.
- It includes all patients within a system in the population.
- It represents all payers.

- It delivers a ready-made patient registry.
- It delivers a roadmap for improvement.
- It provides the foundation for physician pay for performance.

To date, the Wisconsin Collaborative for Healthcare Quality has developed and reported quality on a number of conditions, including diabetes, uncomplicated hypertension, postpartum care, and preventive services (colorectal, mammography, and cervical cancer screening). Its Web-based *Performance & Progress Report* (www.wchq.org/reporting/) consists of a broad and growing collection of performance measures that compare more than 40 reporting provider organizations. Each measure represents a specific aspect of care for a defined period that provides a “snapshot” of a given health care organization’s performance in relation to an evidence-based standard as well as in relation to one another.

Reporting and Performance Improvement

The Wisconsin Collaborative for Healthcare Quality 2005 *Performance & Progress Report* organized the measures into the following categories:

- Access.
- Patient satisfaction.
- Critical care.
- Pneumonia.
- Diabetes.
- Surgery.
- Health information technology.
- Women’s health.
- Heart care.

Reports are available at the physician group, health plan, and hospital levels. The reporting process, which enables physician groups to submit results using a secure Web-based data submission tool, includes two innovative components: a “preview report mechanism” for all reporting entities to use before data are published and a scalable infrastructure that supports significant expansion in measures without changing the reporting platform itself.

The collaborative continues to add participating entities and expand its measures with its unique measures structured so that participants can collect data on all patients within a health system regardless of payer sources, electronic medical record platform, or electronic medical record level of implementation. In 2006, the Wisconsin collaborative released results on preventive care services, such as breast, cervical, and colorectal cancer screening.

Chronic Care Measures

Blood sugar control and screening
 Controlling hypertension
 Kidney function monitoring
 Low-density lipoprotein cholesterol testing
 and monitoring for diabetics

Preventive Measures

Breast cancer screening
 Cervical cancer screening
 Colorectal cancer screening

Impact and Accomplishments

- The Wisconsin Collaborative for Healthcare Quality is a founding member of the Wisconsin Health Information Organization and is responsible for catalyzing its inception. The Wisconsin Health Information Organization is building a data repository to support an expansion in reporting on ambulatory performance. The data will allow providers, employers and consumers to use measures of resource use and cost of care. When these data are combined with the clinical quality measures generated by the Wisconsin collaborative, stakeholders will be able to assess the value of care by looking at cost and quality over an entire episode of care.
- The Wisconsin Collaborative for Healthcare Quality is one of 14 grant recipients of the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative.
- The Wisconsin Hospital Association's Check Point and Price Point initiatives represent a progressive association-based response to the market's demand for information on the quality and cost of hospital services.
- The National Committee for Quality Assurance's 2005 State of Health Care Quality Report ranked six Wisconsin health maintenance organizations among the top 50 health plans. In addition, a 2006 report by the Agency for Healthcare Research and Quality listed Wisconsin as number one among the 50 States for overall quality of health care services.
- The Wisconsin Collaborative for Healthcare Quality has established relationships with key strategic partners, including the Wisconsin Health Information Organization; the Wisconsin Hospital Association; the Wisconsin Medical Society; the University of Wisconsin; the Medical College of Wisconsin; and MetaStar, the Wisconsin Quality Improvement Organization.

Appendix C: Site Visit Framework

Delmarva used roundtable discussions with Better Quality Information (BQI) leaders and stakeholders to capture the rich knowledge and expertise from the six established BQI sites highlighted in this guide. These on-site meetings typically convened for half a day, during which the Delmarva team took notes as the site leaders and stakeholders presented their insights. Delmarva then wrote summaries of the site visits, which the sites vetted and approved for this guide.

Before each site visit, Delmarva sent the BQI team a list of questions to help frame the discussion around key issues pertaining to beginning a regional coalition. These questions are included here to provide the context for site visit summaries and to provide Community Leaders with questions they may want to consider as they form their regional coalition.

Forming a coalition

- How was your coalition initiated? Who initiated it?
 - What was the catalyst for formation, the steps that led up to formation? What were the first steps in creating the coalition? Who set the priorities? How were the priorities set?
- Was there one particular leader instrumental to the formation of the coalition?
- What does it take to form this type of coalition?
 - Timeline
 - Resources
 - Parties involved
- What is your definition of a coalition or collaboration?
- How do you make the business case for forming this type of coalition?
- What is your business model?
- Are there models that helped in forming your coalition?
- What are the barriers you had to overcome?
- What are the lessons you have learned from forming the coalition?
- What are the “rules of engagement” for participation?
- Who are the major stakeholders? What role does each of them play? Who decided who should and should not participate?
- What is your coalition’s mission (purpose and major goals)?
- How have you achieved alignment in your marketplace (prevented the many from going different ways?)
- How have you engaged the various stakeholders? Was there a different strategy for each stakeholder group?

Maintaining relationships in the collaborative

- How are decisions made?
- How is the coalition structured as an organization?
- What is the leadership structure?
- What is the board structure?
- How are decisions communicated?
- What is the organizational culture like?
- What do you perceive to be your successes and challenges?

- What do you do to continuously identify new opportunities?
- How do you maintain alignment and decrease fragmentation between other similar activities within your region?

Evaluating success and progress

- What are your key initiatives? How do you know you are accomplishing your goals? How do you define success?
- How do you know that you are making positive impact?
- How do you measure your success?
- What do you perceive the gaps to be between current knowledge and future requirements?

Sustainability

- What are your plans to sustain or how have you sustained the model you have in place?
- What or who are your funding sources? How did you get the funding stream established? For how long are your funding sources?

Appendix D: BQI Site Visit Summaries

Center for Health Information and Research-Arizona State University Phoenix, Arizona

During the visit to the Center for Health Information and Research on May 21, 2007, the Delmarva team attended the center's weekly staff meeting. The weekly meetings give team members the opportunity to discuss the status of current projects and potential opportunities for new business and to work through any issues the team may be experiencing. Observing the center's weekly staff meeting provided insight on the operational side of running a regional coalition.

Later in the day, Delmarva met with Roger Hughes, executive director of St. Luke's Health Initiatives. During this meeting, Delmarva was able to gain a better understanding of how St. Luke's Health Initiatives has supported Arizona HealthQuery and initiated a new, related research project, namely the Phoenix Healthcare Value Measurement Initiative.

For the last portion of the site visit, Delmarva was invited to observe an Arizona HealthQuery data partner meeting. The meeting brings together all of the data partners to discuss current and future initiatives. A goal of the meetings is relationship building. The idea is that, once the relationships are built and subsequently maintained, the relationships will foster more collaboration and sharing of information, with the ultimate goal of improving community health in Arizona.

During these productive meetings, Delmarva identified five major themes associated with the forming and sustaining of a successful regional coalition:

- The need for visionary leadership in the coalition.
- The importance of establishing the credibility of the project through aligning and affiliating it with national initiatives and well-known community groups and associations.
- Overcoming suspicions and building trust between competing stakeholders and among participating groups and honestly addressing perceived ulterior motives behind participating in any project that involves sharing data among different organizations.
- Tirelessly building and maintaining relationships among a diverse array of community organizations.
- The need for communication with and among stakeholders and for developing effective strategies for marketing the coalition.

California Cooperative Healthcare Reporting Initiative San Francisco, California

The Delmarva team met with the leadership of Pacific Business Group on Health in their San Francisco office on July 18, 2007. In addition to themes already identified during the Arizona site visit, the informative meeting with the experienced group that manages California's innovative coalition yielded many new insights into building and, most importantly, operating an effective regional coalition.

David Hopkins, director of quality measurement and improvement at the Pacific Business Group on Health, and Cathie Markow, senior manager, provided a detailed overview of the projects the California Cooperative Healthcare Reporting Initiative leads or participates in. They also provided practical information on the challenges involved in keeping a coalition moving forward.

With 14 years of experience managing the California coalition, the Pacific Business Group on Health offered practical insight into running a large regional coalition. In particular, Peter Lee, chief executive officer of the Pacific Business Group on Health, stressed the importance of ensuring the expertise of those on the leadership team overseeing key aspects of the coalition. Mr. Lee pointed out that having the right people competently and consistently doing the right job in an unbiased way is crucial to establishing and reinforcing credibility among coalition participants.

Two other important factors in maintaining "buy-in" from the California cooperative's stakeholders are integrating processes for communication and transparency in the coalition's operational structure. Mr. Hopkins and Ms. Markow cited an instance in which they were unable to get charts to participants because their copying service encountered problems with its equipment. Although this glitch caused much anxiety among participants, project staff helped to allay the stress by honestly acknowledging the situation and sending daily updates about what was being done to fix it.

In addition to this initial meeting, the Pacific Business Group on Health team invited Delmarva to observe the California Cooperative Healthcare Reporting Initiative's biannual All Participants Meeting in Oakland on the following day. At this meeting, the cooperative staff presented to stakeholders 2007 results for the:

- Healthcare Effectiveness Data and Information Set (HEDIS) data collection project.
- Health maintenance organization Consumer Assessment of Healthcare Providers and Systems member survey.
- Patient assessment survey.
- Special studies.

During the HEDIS results presentation, the analyst identified quality improvement opportunities based on low rates, large variation across California Cooperative Healthcare Reporting Initiative plans, and poor performance compared to National Committee for Quality Assurance 2006 national percentiles. For measures with rates below 60 percent, the analyst highlighted ones that could potentially be improved through sharing best practices and others that indicate where an opportunity exists for all plans to improve.

Throughout each presentation, members of the group were encouraged to ask questions and raise concerns. At the meeting's conclusion, participants were invited to provide thoughts on opportunities for improvement for particular measures.

During the meeting, the Delmarva team observed California Cooperative Healthcare Reporting Initiative staff members demonstrate their skill sets and dedication to communication with and transparency to participants. Expert analysts contracting with the cooperative presented the data results clearly and thoroughly to the group, while stakeholders were encouraged throughout to ask questions or express concerns.

Massachusetts Health Quality Partners Boston, Massachusetts

The Delmarva team met with the leadership of the Massachusetts Health Quality Partners in their Boston office on July 26, 2007. The group included: Barbra Rabson, executive director; Janice Singer, director of Operations; and Melinda Karp, director of Programs. Additionally, the following members of Massachusetts Health Quality Partners' governing board contributed to the discussion: Harris Berman, M.D., board chair; Judith Melin, M.D., Physician Council representative; John Mason, Ph.D., Health Plan Workgroup representative who works for Blue Cross Blue Shield of Massachusetts; and David Smith, board representative and senior director of health data policy who works for the Massachusetts Hospital Association.

The site visit built on key themes raised during the Arizona and California site visits, such as carefully building and maintaining trust with stakeholders. The Massachusetts coalition brands itself as a source of trusted information. According to Ms. Rabson, Massachusetts Health Quality Partners earns its reputation as a trusted source of information because of its collaborative process.

In this process, those being measured are involved in the measurement and reporting process, data aggregation across health plans results in more robust performance data, and the coalition's attention to methodology results in more reliable information. Massachusetts Health Quality Partners also provides a consensus-driven context for how the data can be used rather than simply providing data that are open to interpretation and available to all (i.e., a more "neutral" data source).

The group also reinforced the need during the startup of a coalition for visionary leaders who will tirelessly drum up community support and convey the importance of developing effective communication strategies. In particular, Ms. Rabson and Mr. Smith stressed the highly sensitive nature of public reporting and how, if not communicated well, it can cause much more harm than good.

Group members related how Boston health care leaders convened Massachusetts Health Quality Partners after a Boston Globe article in 1994 published mortality rates in Massachusetts hospitals. Consequently, Ms. Rabson emphasized how effective and consistent communication with the press and stakeholders is critical to the ongoing success of a regional coalition.

The group also spoke on the Massachusetts Health Quality Partners Physician Council, a unique aspect of the coalition's governance. The Physician Council has helped the coalition engage a broad range of physician groups in the collaborative process and in governing the coalition. Among the responsibilities physician groups share on the council is selecting two representatives from its members to serve on Massachusetts Health Quality Partners' board of directors.

Minnesota Community Measurement St. Paul, Minnesota

The Delmarva team met with a large group of Minnesota Community Measurement staff and stakeholders in St. Paul on August 2, 2007. The group included:

- Diane Mayberry, director of program development.
- Michelle Ferrari, project manager.
- Carrie Trygstad, project manager.
- Anne Snowden, director of quality reporting.
- Julie Brunner, Minnesota Council of Health Plans.
- Brian Osberg, Minnesota Department of Human Services.
- Becky Sherman, Minnesota Medical Association.
- Doug Hiza, First Plan of Minnesota.
- Terry Murray, director of quality management at Quello Clinic, Ltd.
- Linda Davis, a consultant for LCS Solutions.

During the meeting, the group presented an overview of the coalition's origin, structure, challenges, and accomplishments over the previous 5 years.

All of the major themes that emerged during previous site visits were reinforced by Minnesota Community Measurement's successful experience:

- Having visionary leadership that can bring together diverse interests.
- Establishing the coalition's credibility.
- Building relationships and continually earning the trust of participants.
- Creating a process that effectively gathers, validates, and reports data.
- Cultivating media relationships and developing public relations strategies.
- Being alert for unexpected legal issues (in this case, antitrust concerns).
- Evolving from an informal group or project to a formal organization.

One aspect of the coalition's background was significantly different from the other sites visited thus far: Minnesota's nonprofit health care system. The nonprofit system fosters an inherently collaborative culture that is more conducive to building a coalition than a competitive, for-profit health care market. The legislature also has mandated quality improvement and public reporting in health care.

Although other sites have expressed the need to persuade stakeholders that quality should rise above competitive interests, Minnesota's health plans agreed from the beginning that competing on the quality of clinical health care would not contribute to improving the quality of care or health overall. Although this predisposition toward collaboration made it easier for stakeholders to work together on improving quality of clinical care, issues of building trust and credibility and ensuring the transparency of the process were still crucial factors in building the coalition.

Although quality of clinical health care competition may not be a big factor in Minnesota, skepticism and a reluctance to cooperate are still issues with which the Minnesota coalition contends. A key lesson the coalition has learned is that listening to skeptics and bringing them into the process strengthens and enhances the coalition's product.

Indiana Health Information Exchange Indianapolis, Indiana

The Delmarva team met with the leadership of the Indiana Health Information Exchange in their Indianapolis office August 15, 2007. The group included:

- J. Marc Overhage, M.D., Ph.D., chief executive officer and president.
- Greg Larkin, MD, director of corporate health services for Eli Lilly.
- Dave Kelleher, president of HealthCare Options, Inc., and executive director of the Employers' Forum of Indiana.
- Tom Penno, chief operating officer.
- Chris Schultz, director of clinical quality.
- Debbie Banik, M.H.A., program director for clinical messaging services.
- Jennifer Siminski, marketing and public relations director.

The Indiana Health Information Exchange shares many thematic similarities with the other Better Quality Information (BQI) sites, but a key difference is the method in which the Indiana coalition began. While the other sites initially focused on public reporting and later moved toward developing value-added services for participants, the Indiana coalition started as a way to create value and marketable services for stakeholders. The importance of this difference is that the Indiana Health Information Exchange has developed a number of self-sustaining services. One example is the DOCS4DOCS® Clinical Messaging Service that delivers patient data results directly to physicians. The Indiana exchange recognizes that second- and third-generation products that spin off from this service may create potential sources of funding. Other sites, such as Massachusetts Health Quality Partners and Minnesota Community Measurement, are exploring ways to generate revenue to support coalition activities (for example, Massachusetts Health Quality Partners offers oversampling of data for clients).

The Indiana coalition has successfully worked with other groups in the country in replicating Indiana's health information services. In Tennessee, for example, the Indiana Network for Patient Care model helped a group move from an informal group of stakeholders to a fully running coalition within 3 years. However, as the exchange points out, one potential drawback to its approach may be that, as it moves forward with public reporting, it does not have the same cohesion among stakeholders that other BQI sites have cultivated during the startup phase. The coalition has primarily concentrated on developing services in the Indianapolis area, and as it begins to expand regionally, it may encounter challenges in getting buy-in for public reporting from statewide associations.

Although the Indiana Health Information Exchange's origins are alike with academic and other community organizations, health providers, and grassroots efforts, its entrepreneurial approach also has been influenced by large Indiana employers like Eli Lilly and Company, General Motors, Anthem Blue Cross Blue Shield, and WellPoint. In particular, Eli Lilly played a prominent role in convening leadership to provide internal support and structure to the Quality Health FirstSM program. One of the important lessons learned from this approach is that smaller employers often do not have the time or energy to focus on the health issues central to regional coalitions. Many of these employers look to the large employers, like Eli Lilly, and follow its lead.

The Indiana Health Information Exchange site visit also reinforced a recurring theme about the role of public reporting and consumers. Because many consumers do not have time to seek out data

reporting or understand the complexities behind it, the Indiana team used two business truths to underscore its concern about focusing too much of its efforts on consumers:

- Many people buy mutual funds because they lack the time or knowledge to research stocks.
- Consumer ratings on cars mostly serve to motivate car manufacturers.

The Indiana coalition also has an entrepreneurial focus that uniquely addresses the question of sustaining regional coalitions. Its leadership has developed a number of business ventures around the Indiana Network for Patient Care database that not only provide valuable services, but also directly improve health care delivery.

The exchange has successfully generated revenue through its DOCS4DOCS® services. This service creates value because it:

- Reduces the need to create outbound interfaces as providers adopt electronic health records.
- Offers faster, cheaper, more reliable delivery of results.
- Requires less effort to maintain physician contact information.
- Provides economies of scale.
- Frees health care personnel to provide billable services rather than answering the phone and finding misplaced or undelivered results.
- Creates increased provider satisfaction from a single source for their clinical results.

Wisconsin Collaborative for Healthcare Quality Madison, Wisconsin

The Delmarva team met with a large group of Wisconsin Collaborative for Healthcare Quality staff and stakeholders in Madison August 23, 2007. The group included:

- Chris Queram, president and chief executive officer.
- Don Logan, M.D., medical advisor.
- Jack Bowhan, administrator and medical management, Dean Health System.
- Cheryl DeMars, chief executive officer of The Alliance.
- Kirsten Albers, Meriter Hospital, the first organization to join when the collaborative became a membership organization in 2004.
- Chris Baker, administrative director for quality and safety systems, St. Mary's Hospital.

The group presented an overview of the coalition's origin, structure, challenges, and accomplishments since its founding in 2002. Although Delmarva observed many thematic similarities with the other Better Quality Information (BQI) sites, a key difference is Wisconsin's physician-driven approach. Where other "payer-centric" sites have worked hard to establish credibility among providers, the Wisconsin Collaborative for Healthcare Quality began with physicians and draws its data from them.

Participants' comments underscore the observation that coalitions in the Midwestern part of the United States develop more easily in the inherently collaborative culture of the region. However, unlike in Minnesota, where a nonprofit health care system is mandated by the legislature, there are tensions emerging in Wisconsin between for-profit commercial plans and not-for-profit, physician-sponsored health care in the State. These tensions are most evident in the Wisconsin collaborative's relationship with the Wisconsin Health Information Organization, which the collaborative helped launch in 2005 to create an administrative claims database measuring and reporting the resource use and cost of care for ambulatory services.

Based on its experiences, the Wisconsin collaborative identifies effective communication between purchasers and providers as a key element of its success. It is important to clearly define who will be driving the effort and to what end. For example, participants cannot use data for marketing purposes. Because payers and providers often define and use terms differently, the coalition makes certain that all participants agree on what terms, such as collaborate and partnership, mean in the context of coalition.

As an example of the strength derived from teamwork, the Wisconsin Collaborative for Healthcare Quality benefits tremendously from the participation by one of its business partners, The Alliance. This employer-owned and -directed not-for-profit cooperative provides a variety of in-kind services to the collaborative, including the preparation of risk-adjusted charge data used in the coalition's innovative "quadrant analysis" for hospital efficiency, a unique relationship among the BQI sites. Founded in 1990, The Alliance has developed a network of health care providers on behalf of its more than 170 member employers and their 85,000 employees and dependents. Through its QualityCounts™: Consumer Information for Better Health Care" initiative, The Alliance also publishes its own quality ratings of local health care providers to help consumers make more informed health care decisions.

The Wisconsin Collaborative for Healthcare Quality also reinforced a recurring theme about the role of public reporting and consumers. The coalition sees public reporting as more effectively

helping clinicians to measure and improve their work, while recognizing the importance of assessing methods to make its information more relevant to and accessible by consumers.

Appendix E: Mentor Contact List

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Wisconsin Collaborative for Healthcare Quality

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Appendix F: Resources

Better Quality Information Sites

Center for Health Information and Research-Arizona State University

<http://chir.asu.edu>

660 South Mill Avenue, Suite 312

Tempe, Arizona 85281

480-965-0122

chir@asu.edu

St. Luke's Health Initiatives (http://www.slhi.org/ahf_projects/phvmi/over_descr.shtml) was a previous sponsor.

California Cooperative Healthcare Reporting Initiative

<http://www.cchri.org>

c/o Pacific Business Group on Health (<http://www.pbgh.org>)

221 Main Street, Suite 1500

San Francisco, CA 94105

415-281-8660

cmarkow@pbgh.org

Massachusetts Health Quality Partners

<http://www.mhqp.org>

100 Talcott Avenue

Watertown, MA 02472

617-402-5020

info@mhqp.org

Minnesota Community Measurement

<http://www.mnhealthcare.org>

2550 University Avenue W.

Suite 245N

St. Paul, MN 55114-1904

651-209-0390

info@mnhealthcare.org

Indiana Health Information Exchange

<http://www.ihie.com>

846 N. Senate Avenue, Suite 300

Indianapolis, IN 46202

317-664-1750

info@ihie.com

In conjunction with the Regenstrief Institute (<http://www.regenstrief.org>), the Indiana Health Information Exchange runs the Quality Health FirstSM program (<http://www.qualityhealthfirst.com>),

a clinical quality program for health and chronic disease management that provides standardized quality measures used by physicians and health insurers.

Wisconsin Collaborative for Healthcare Quality

<http://www.wchq.org/index.php>

PO Box 258100

Madison, WI 53725-8100

608-250-1223

608-294-3903 (fax)

info@wchq.org

Miscellaneous

Co-opetition: A Revolution Mindset That Combines Competition and Cooperation: The Game Theory Strategy That's Changing the Game of Business, Adam M. Brandenburger and Barry J. Nalebuff. New York: Doubleday, 1996.

<http://mayet.som.yale.edu/coopetition/index2.html>

Network for Regional Healthcare Improvement

<http://www.nrhi.org>

The Network for Regional Healthcare Improvement accelerates improvement in the quality and value of health care delivery in the United States by building and strengthening regional multistakeholder coalitions and influencing national policy for regional coalitions.

Quality Measurement and Improvement

Agency for Healthcare Research and Quality Report Card Compendium

<http://www.talkingquality.gov/compendium>

A searchable directory of health care “report cards” that provide comparative information on the quality of health plans, hospitals, medical groups, individual physicians, nursing homes, and other providers of care.

Consumer Assessment of Healthcare Providers and Systems Surveys and Reporting Kit

<https://www.cahps.ahrq.gov/CAHPSkit/Healthplan/HPChooseQx2.asp>

This kit provides documentation for both the current 3.0 version and the new 4.0 version of the CAHPS Health Plan Survey.

Institute for Healthcare Improvement

<http://www.ihl.org/ihl>

The Institute for Healthcare Improvement is a not-for-profit organization leading the improvement of health care throughout the world.

The Healthcare Effectiveness Data and Information Set

<http://web.ncqa.org/tabid/59/Default.aspx>

The Healthcare Effectiveness Data and Information Set is a tool that more than 90 percent of America’s health plans use to measure performance on important dimensions of care and service.

Value-Driven Health Care

<http://www.hhs.gov/valuedriven/>

The Department of Health and Human Services Web site provides extensive information about the Value-Driven Health Care initiative.