Oregon Health Fund Board
Delivery Committee Quality Institute Work Group Meeting

Thursday, April 10, 2008
9:00 – 10:00 am

Location for Public Participation:
General Services Building
Neahkanie Room, 1st Floor
1225 Ferry Street SE
Salem, OR

AGENDA

Time (est)	Item	Lead	Action Items
9:00 am	Call to Order and Review of 3/21 Minutes	Vickie Gates	
9:05 am	Discussion and Approval of Final Quality Institute Work Group Recommendations	Vickie Gates	X
9:45 pm	Public Testimony	Vickie Gates	
10:00 pm	Adjourn	Vickie Gates	

OREGON HEALTH FUND BOARD (OHFB)
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORKGROUP

March 21, 2008
1:00 pm to 5:00 pm

Portland State Office Building Rm 1B
800 NE Oregon Street
Portland, OR

MEMBERS PRESENT:
Vickie Gates, Chair (by phone)
Bob Johnson, DMD
Nancy Clarke
Jim Dameron
Gwen Dayton
Kathy Savicki
Brett Sheppard, MD
Richard Cohen, MD (by phone)
Maribeth Healey, Vice-Chair
Ralph Prows, MD

MEMBERS EXCUSED:
Gil Muñoz
Mike Williams
Maureen Wright, MD
Glenn Rodríguez, MD

STAFF PRESENT:
Jeanene Smith, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Data and Research Manager, OHPR
Ilana Weinbaum, Policy Analyst, OHFB
Zarie Haverkate, Communications Coordinator, OHPR

OTHERS ATTENDING:
Carol Turner, Facilitator

ISSUES HEARD:

- Call to Order, Introductions and Approval of 03/14/08 Minutes
- Review Work Group Recommendations: Issues for further Discussion (Private Funding, Role Prioritization, Alignment with other efforts)
- Approve Recommendations with Amendments
- Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Digitally Recorded

Vice Chair Healey **I. Call to order, Introductions and Approval of 03/14/08 Minutes (See Exhibit Materials 2)**

- Meeting was called to order at 1:14 p.m.
- There was a quorum.
- Review and approval of minutes.

Vice Chair Healey/ Carol Turner, Facilitator **II. Review Work Group Recommendations: Issues for further Discussion (Private Funding, Role Prioritization, Alignment with other efforts) (See Exhibit 3)**

Facilitator Carol Turner recommended identifying areas of consensus and no consensus.

(Underlined statements in document are additions from last meeting.)

- Funding (page 5)
  - Bullet 3:
    - Concern for seeking funding during an economic downturn from stakeholders expressed.
    - Change last sentence from "Quality Institute will seek additional funding . . ." to ". . . may seek. . ."
    - Make last sentence a separate bullet.
    - For additional funding, include cautionary statement that money is not taken from other efforts.
    - Suggested that added bullet also relate that nothing should preclude the organization from embarking on other projects and collaborations and other grant funding, etc.
    - Not hybrid funding, but work will be hybrid.
    - Reporting to the legislature on QI discussed.
    - Leverage to coordinate existing work, not duplication (e.g. Q-Corp and Patient Safety Commission, which are funded by providers).
    - Need to make it clear that a robust quality system will receive "more bang for a buck."
    - Quality is a separate issue from regulation.
      - Discussion on the rational and variables of funding amount of $1 million.
      - Make a statement saying that it is significant but humble.
      - Reference points are Maine and Q-Corp.
      - Goes for output as well as speed of execution. Output=efficiency.
- Data Collection (page 6)
  - Bullet 5, last sentence
    - Implies it is imposing a requirement rather than the QI being allowed to collect data.
    - Concern expressed over making it voluntary as it will result in uneven reporting.
    - Boundaries are needed.

        - The system may be a combination of mandatory and voluntary reporting.
    - Bullet 5, first sentence
        - Discussion of the use of the term "consumer experience" as relating to patient satisfaction, quality of care and the impact of patient's perception on achieve a good outcome.
        - Discussion on adding "outcome."
        - Include quality of care, patient outcomes and utilization of health care resources.
    - Bullet 5, first sentence – discussion regarding QI publishing data.
        - Ability to publicize in coordination with organizations publishing data.
        - Will it be available for researchers to cite in published work?
    - Bullet 3
        - Drop "community" from sentence.
- Doer-Supporter Role
    - Bottom of page 18, last complete sentence,
        - remove "more" from "more likely"
    - Page 19 , last sentence to read "At the same time, it is likely that the Quality Institute will often direct, support and fund as well as directly carry out . . ." Prioritize Roles/Tasks
    - Page 16, last paragraph to top of 17
        - Consolidate and coordinate data. Coordinate, align and endorse common measurements.
    - Discussion on what should be the first role of QI.
        - Reorder the bullets from page 6 and 7 to 1, 2, 5, 6, 4.
- Medical Home/Behavioral Health
    - Consensus on language on page 17 as written.
- Publicly Chartered Organization (vs. Public Corporation)
    - Include reasons for a QI as a publicly chartered organization:
        - State funds
        - Liability protection
        - Statutory mandate
        - Data confidentiality protection
        - Ability to make rules
        - Health oversight agency
        - Flexibility
    - Page 18
        - 2nd bullet - should read "long term state funding."
        - 4th bullet – remove the word "all."
- Transparency
    - Appropriateness, feasibility and reasonable availability of transparency discussed and identified in document.
    - Page 6, 2nd Bullet
        - Add sentence: Balancing value of data vs. burden of consolidation (use Acquired Infection Language).
- QI Relationship to Other Organizations
    - Consensus on language as written.

- Impact/Description of QI
  - Page 12, Assumptions 1 and 3 discussed.
  - Discussion on capturing the core statement for QI from:
    - page 4 (bottom of 2nd paragraph): ". . . Quality Institute to serve as a leader and unify existing efforts . . ."
    - page 12 under first assumption: "The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives . . ."
    - page 6, first sentence: "The overarching role will be to lead Oregon toward a higher performing health care delivery system by…
    - page 12 under first assumption, last sentence: "Quality improvement and increased transparency. .
    - two keystones of the core are quality, access and transparency. Making a bold statement about quality is suggested.
    - Staff will draft and return to the Committee for review.

Vice Chair Healey **III. Approve Recommendations with Amendments**

Committee reached a consensus to approve the draft as amended.

Vice Chair Healey **IV. Public Testimony**

Scott Gallant, Oregon Medical Association, provided testimony on the clarity, reducing burden on physicians for providing data and credentialing. Response by Committee and discussion.

(**II. Review of Work Group Recommendations continued)**

- After hearing testimony, the Committee agreed to amend page 15 of document to include "lessen the burden of data collection and reporting that currently complicates the provision of health care."
- Discussion of raising the requested amount to $2 million dollars. Sean Kolmer and Ilana will develop a more exact budget based on experience in Oregon and other states and add appendix to support funding request. In addition, funding should be indexed for increases over the ten-year period.
- Clear statement on protection of individual physician and individual patient identity suggested. Board of Medical examiners charge is to deal with physicians practices.
- Clarification of why "utilization of health care resources" (page 6, bullet 6) was added.

Facilitator Carol Turner debriefed the committee including identifying what worked well and what would be changed.

The Committee thanked the staff for its work.

Vice Chair Healey **XI. Adjourn**

Meeting adjourned at approximately 4:40 p.m.

Next meeting is by phone to approve changes to report for delivery to Delivery Systems Committee on April 17.

Submitted by:
Paula Hird

Reviewed by:
Ilana Weinbaum

EXHIBIT SUMMARY
1. Draft Agenda
2. Draft Minutes from 03/14/08
3. QI Recommendations

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

April 10, 2008

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Work Group Membership

Vickie Gates, Chair
Health Care Consultant
Oregon Health Policy Commission
Lake Oswego

Maribeth Healey, Vice-Chair
Director
Oregonians for Health Security
Clackamas

Nancy Clarke
Executive Director
Oregon Health Care Quality Corporation
Portland

Richard Cohen, MD
Physician
Grants Pass

Jim Dameron
Administrator
Oregon Patient Safety Commission
Portland

Gwen Dayton
Executive Vice President and Chief Counsel
Oregon Assn. of Hospitals & Health Systems
Lake Oswego

Robert Johnson
Chair
Department of Community Dentistry
OHSU School of Dentistry
Portland

Gil Muñoz
Chief Executive Officer
Virginia García Memorial Health Center
Hillsboro

Ralph Prows, MD
Chief Medical Officer
Regence of Oregon
Portland

Glenn Rodríguez, MD
Chief Medical Officer, Oregon Region
Providence Health System
Portland

Kathy Savicki
Clinical Director
Mid-Valley Behavioral Care Network
Salem

Brett C. Sheppard, MD
Professor and Vice-Chairman of Surgery
Oregon Health & Science University
The Digestive Health Center
Pancreatic/Hepato Biliary and Foregut Units
Department of General Surgery
Portland

Maureen Wright, MD
Assistant Regional Medical Director of Quality
Kaiser Permanente Northwest Region
Portland

Mike Williams
Attorney
Williams Love O'Leary & Powers, P.C.
Portland

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Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Report Index

Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Preamble

Ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system. An Oregon Quality Institute will serve as a leader to unify existing quality efforts and lead Oregon toward a higher performing health care delivery system. Long term, stable state investment in and dedication to quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient, and equitable.

I. Background

Based on recommendations from the Oregon Health Policy Commission (OHPC), Senate Bill 329 (2007), the Healthy Oregon Act, directs the Administrator of the Office for Oregon Health Policy and Research to develop a model Quality Institute for Oregon as part of the larger health reform planning process established by the bill. The Oregon Health Fund Board assigned this task to the Delivery Systems Committee and chartered a Quality Institute Work Group to develop recommendations regarding the appropriate structure and roles for an Oregon Quality Institute. The Quality Institute would coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery.

The preamble of SB 329 calls for health reform policies that encourage the use of quality services and evidence-based treatments that are appropriate, safe and discourage unnecessary treatment. Research illustrates that the current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[1] In addition, quality of care varies significantly depending on where in the state a patient receives care, as does the utilization of specific procedures and treatment options.[2] While there are numerous public and private efforts underway across the state to

[1] Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[2] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency.

The availability of clear and transparent information is the keystone to any health care reform plan, including the current effort to improve the quality of care delivered by Oregon's health care system. The Institute of Medicine's Ten Rules to Redesign and Improve Care calls for shared knowledge and the free flow of information and transparency across the health care system.[3] In addition, President Bush's Four Cornerstones for Healthcare Improvement Executive Order of 2006 calls for greater health system transparency through wider availability of health care quality and price data.[4] Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. Therefore, an Oregon Quality Institute is needed to ensure that appropriate and actionable information is available across the health care system and that stakeholders have the tools and knowledge needed to use this information to improve quality of care. A collaborative and well-supported effort to improve quality and increase transparency is a vital part of any effort to transform Oregon's health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

II. Recommendations for a Model Oregon Quality Institute

The Quality Institute Work Group of the Oregon Health Fund Board Delivery Systems Committee recommends the formation of a Quality Institute for Oregon. The Institute will be established as a publicly chartered public-private organization, giving it legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports and must provide the same protections to information submitted by other organizations.

The Work Group makes the following recommendations about the structure, governance and funding for a Quality Institute for Oregon:

- A Board of Directors of the Quality Institute will be appointed by the Governor and confirmed by the Senate and include no more than 7 members. Members must be knowledgeable about and committed to quality improvement and

[3] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.
[4] U.S. Department of Health and Human Services, Value-Driven Health Care Home. http://www.hhs.gov/valuedriven/index.html

represent a diverse constituency. The Board should be supported by advisory committees that represent a full range of stakeholders. The Administrator of the Office for Oregon Health Policy & Research, or a designee, shall serve as an Ex-Officio member of the Board.

- The Quality Institute will have an Executive Director, who is appointed by and serves at the pleasure of the Board. The Quality Institute will have a small professional staff, but should partner or contract with another organization to provide administrative support.
- In order for the Quality Institute to be stable, state government must make a substantial long-term financial investment in the Quality Institute by providing at least $2.3 million annually for a period of at least 10 years (See Appendix C). Following the 2009-11 biennium, this budget should be adjusted to account for inflation.
- The Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts. In addition, nothing precludes the Quality Institute from seeking additional voluntary funding from private stakeholders and grant-making organizations to supplement state appropriations.

The Quality Institute's overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission). To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported, and goals will be regularly updated to encourage continuous improvement.

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities.

3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and

patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.

4. Ensure the collection (by coordinating and consolidating collection efforts and directly collecting data when not available) and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting whenever possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data and/or may support other organizations in publishing data.

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures.

- Lessen the burden of reporting that currently complicates the provision of health care.

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care and evaluate quality improvement initiatives.

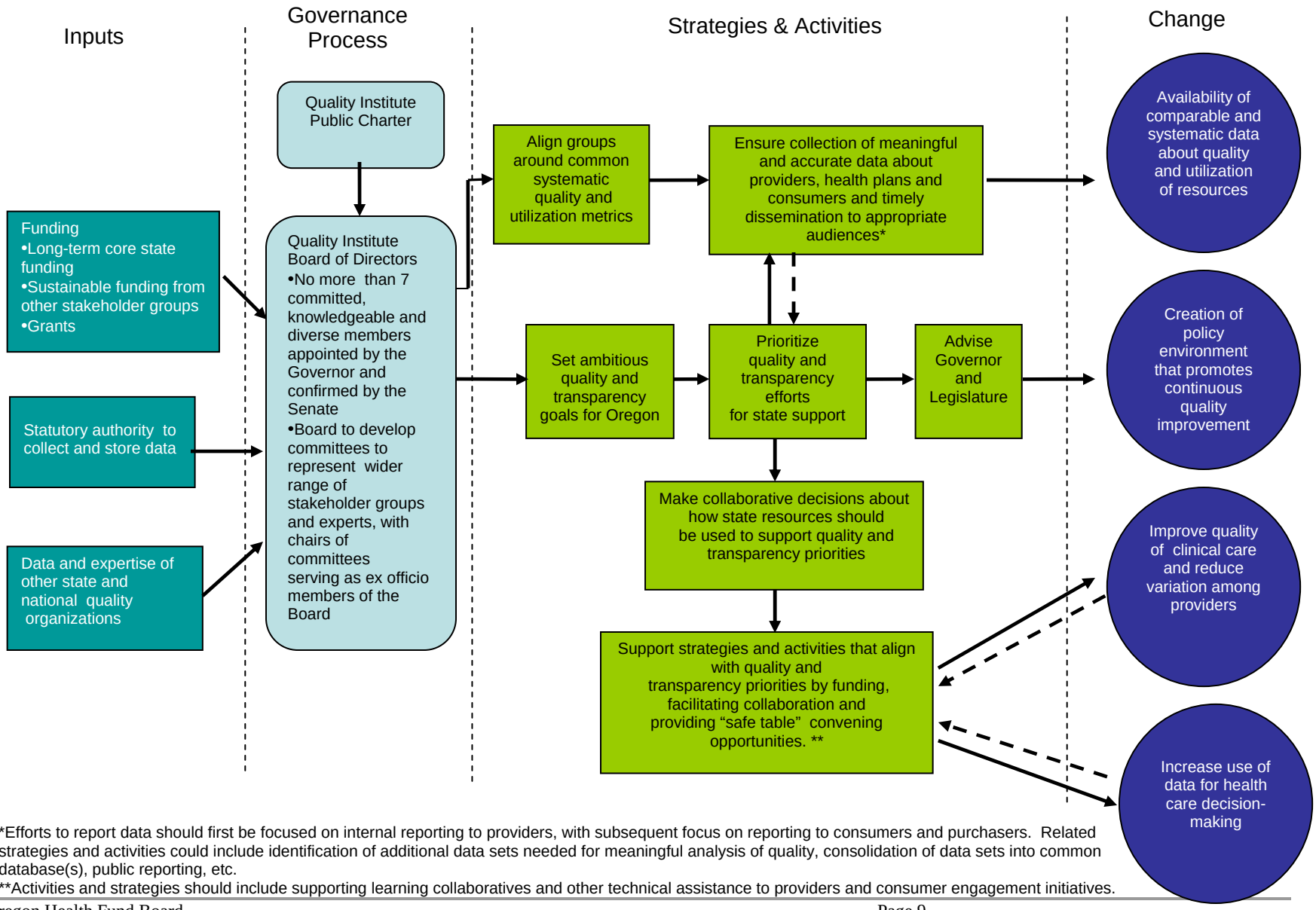
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

III. Logic Model for an Oregon Quality Institute

The Quality Institute Work Group constructed a "theory of change" logic model to provide a pictorial representation of its recommendations for an Oregon Quality Institute. The logic model attempts to represent the range of inputs, governance process, strategies and activities the group believes would be required to develop a Quality Institute successful in achieving the following goals:

- Ensure availability of comparable and systematic data about quality and utilization of resources;
- Create a policy environment that promotes continuous quality improvement;
- Improve the quality of clinical care; and
- Increase the use of quality data for health care decision-making.

Logic Model for a Quality Institute for Oregon



*Efforts to report data should first be focused on internal reporting to providers, with subsequent focus on reporting to consumers and purchasers. Related strategies and activities could include identification of additional data sets needed for meaningful analysis of quality, consolidation of data sets into common database(s), public reporting, etc.

**Activities and strategies should include supporting learning collaboratives and other technical assistance to providers and consumer engagement initiatives.

IV. Work Group Process

The Quality Institute Work Group began their formal deliberations in December of 2007 and held seven meetings. Membership was drawn from a wide range of stakeholder groups and included many of the same people who served on the Oregon Health Policy Commission Quality and Transparency Work Group.

At its first substantive meeting in January 2008, the group was joined by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University, who is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the Work Group's charge, discussed 'Theory of Change' models of behavior change and presented examples and results of quality improvement efforts from around the country. Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings.

In an effort to identify existing gaps in quality and transparency efforts in Oregon and identify possible areas for collaboration and coordination, the work group built on efforts of the Oregon Health Policy Commission Quality and Transparency Work Group to assess the current landscape in Oregon. The following organizations and collaborative initiatives dedicated to quality improvement and transparency were identified and discussed:

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Compare Hospital Costs Website
- Department of Human Services
- The Foundation for Medical Excellence
- Health Insurance Cost Transparency Bill – HB 2213 (2007)
- The Health Care Acquired Infections Advisory Committee
- Independent Practice Associations and Medical Groups
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Community Health Information Network (OCHIN)
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Hospital Quality Indicators
- Oregon IHI 5 Million Lives Network
- Oregon Patient Safety Commission
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance

- Public Employees Benefits Board and Oregon Educators Benefits Board
- Regence Blue Cross Blue Shield

Appendix A provides a matrix that describes these efforts.

The Work Group also examined quality and transparency efforts in other states, focusing on initiatives in Maine, Massachusetts, Minnesota, Pennsylvania, Washington, and Wisconsin. Appendix B provides a description of select quality and transparency efforts in these states.

V. Definitions of "Quality" and "Transparency"

When the Work Group reviewed its charter from the Oregon Health Fund Board at its first meeting, members quickly identified a need to develop standard definitions of *quality* and *transparency*.

Members noted that a number of organizations in Oregon, including the Oregon Health Care Quality Corporation, have incorporated the Institute of Medicine's (IOM) definition of quality, which includes the six domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Members also acknowledged the work of the U.S. Department of Human Services' Agency for Healthcare Research and Quality (AHRQ) in the area of quality. On January 3, the Work Group approved the definition of *quality* found below, which combines definitions presented by the IOM and AHRQ.

Quality

As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- **Safe –** avoiding injuries to patients from the care that is intended to help them.
- **Effective –** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered –** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely –** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient –** avoiding waste, including waste of equipment, supplies, ideas, and energy.

- **Equitable –** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

AHRQ has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

The group could not identify a widely accepted definition of *transparency* and had to combine language from various sources with members' best thinking. The concept of "clarity in relationships" was taken from a 2006 article about transparency in health care that appeared in the American Heart Hospital Journal.[5] The Work Group approved the definition below on January 10.

Transparency
A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. ***To the extent practicable and appropriate, a transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats.*** This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services (value = quality/cost) provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

VI. Problem Statement

The Quality Institute Work Group also drafted a statement of the problems in the current health care system that could potentially be addressed by an Oregon Quality Institute:

- Need for a robust mechanism to coordinate statewide quality improvement and transparency efforts. Currently, we have:
    - Multiple agencies, organizations, providers and other stakeholder groups furthering quality and transparency efforts, without unifying coordination
    - No mechanism for setting common goals around health care quality or a public quality agenda
    - A need for stronger mechanism for sharing of best practices, successes and challenges across efforts

[5] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

  - Missed opportunities for synergy, efficiency, and economies of scale possible through partnership along common goals
- No comprehensive measurement development and measurement of quality across the health care delivery system
  - Consumers and purchasers have limited access to comparable information about cost and quality
  - Providers have limited ability to compare their own performance with peers and to make referral decisions based on quality and cost data
  - Providers are required to report different measures to different health plans and purchasers
- Limited resources dedicated to quality improvement and transparency
  - Lack of resources to support coordination across quality and transparency efforts
  - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
  - Need for systemic mobilization and planning for use of resources in a manner that maximizes system wide impact and reduces duplicative efforts
- Wide variability between providers in quality and cost of care
- Lack of infrastructure (both human and technology) necessary to assess system wide performance and use data to develop a systemic approach to quality improvement
- Lack of systematic feedback and credible data to improve clinical care systems
- Need for new tools to help consumers, purchasers, and providers effectively use data to make treatment and coverage decisions

VII. Assumptions

The Quality Institute Work Group next worked to clarify the starting assumptions that the group would use to identify the appropriate roles and structure of an Oregon Quality Institute. The starting assumptions went through a number of iterations and the group approved the set below.

Assumption 1*:* The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality, increase transparency, and reduce duplication across stakeholder groups. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and equitable, and better able to contain costs.

Assumption 2: The Quality Institute will be an essential element of any sustainable health care reform plan and should play an integral and long-term role in improving quality and increasing transparency across Oregon.

Assumption 3: The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience. These partnerships should be developed in a manner that allows for assessment of the fundamental capabilities of the health care system in Oregon, identification of opportunities to effect change across the system, and monitoring of quality improvement and cost savings from quality improvement across the entire system.

Assumption 4: The Quality Institute will need to be supported by sustainable, stable and sufficient resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system. A broad base of funding, including dedicated public resources and resources from other stakeholders, will be necessary to make progress in quality and transparency.

VIII. Roles of the Quality Institute

The next task for the Quality Institute Work Group was to make recommendations about the appropriate roles of a Quality Institute for Oregon, given the group's problem statement and assumptions. Staff created a draft list of potential roles, based on quality improvement strategies used in other states, as well as other published sources, including the IOM's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.[6] The initial draft list included twelve possible roles, which were categorized using a framework presented by Dennis Scanlon. Each option was categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The facilitator led the group in several rounds of discussion and revision of the role options, with the group analyzing each proposed role, adding additional roles, scoring roles, eliminating roles that were not appropriate for a Quality Institute and combining roles that were redundant. In addition, the group developed a framework for categorizing roles that fall under the auspices of the Quality Institute. The categories

[6] Institute of Medicine. (2005). Performance Measurement: Accelerating Improvement. National Academies of Press. Washington, D.C.

the group settled on were *Coordination and Collaboration, Systematic Measurement of Quality, Provider Improvement and Technical Assistance, Consumer Engagement and Policy Advising.*

The Work Group also identified some of the roles as priorities that should guide the Quality Institute in its initial work. These roles focus on establishing a coordinated quality and transparency agenda for Oregon and developing a systematic performance measurement process. Once the Quality Institute is successful in achieving these goals, members felt that the Quality Institute should use data and evidence to determine where initiatives related to the remaining roles could be most effective. The Quality Institute's budget will determine the extent to which the Institute is able to pursue these additional roles.

Overarching Role

The Quality Institute will lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission).

To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement (Coordination and Collaboration).

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities (Coordination and Collaboration).

3. Ensure the collection (by coordinating and consolidating collection efforts and directly collecting data when not available) and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in

appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting to the greatest extent possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data or may support other organizations in publishing data (Systematic Measurement of Quality).

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[7]:

- Measures and methodology should be transparent;
- Those being measured should have the opportunity to provide input in measurement systems (not be "surprised") and have opportunities to correct errors;
- Measures should be based on national standards to the greatest extent possible;
- Measures should be meaningful to consumers and reflect a robust dashboard of performance;
- Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting; and
- Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient-centered).

4. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives (Provider Improvement and Technical Assistance).

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate (Policy Advising).

As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

[7] Adopted from the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. For more information, see http://healthcaredisclosure.org.

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered (Coordination and Collaboration).

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures (Coordination and Collaboration).

- Lessen the burden of reporting that currently complicates the provision of health care (Provider Improvement and Technical Assistance).

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement (Provider Improvement and Technical Assistance).

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care, and evaluate quality improvement initiatives. (Provider Improvement and Technical Assistance).

- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health (Consumer Engagement).

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10-year vision, supported by the funding and resources required

to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders will need to make a long-term commitment to the goals of improved quality and increased transparency.

In developing recommendations for the appropriate roles for a Quality Institute, the group spent significant time discussing the types of data that would be most useful to stakeholders in assessing quality and driving quality improvement efforts. There was general agreement that cost is one of the potential factors important to the assessment of efficiency. An example considered by the group was the use of generic medication. Cost is part of the value equation (value = quality/cost), but members were aware that it is also a more complex indicator than often realized. Some members cautioned that reporting cost data alone does not provide useful "apples to apples" comparisons, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care. For instance, simply comparing the average price of normal births at two different hospitals would not account for these differences. There were a few members that expressed the view that this information should still be made available with clear explanations of its limitations, but there was general consensus among the members that the Quality Institute should focus on collecting and reporting data directly related to the quality and efficiency of care. The group agreed that an analysis of geographic variations in utilization of health care resources can provide important insight into quality and thus is an appropriate role of a Quality Institute. Members highlighted the value of work done at the Dartmouth Atlas Project in describing variation in health resource utilization between hospitals serving Medicare patients. [8]

The Work Group discussed a number of different strategies and activities that the Quality Institute might decide to use to ensure the collection and timely dissemination of systematic data about quality and utilization. While the group decided that the Board of the Quality Institute will determine how best to fulfill this role, the group discussion highlighted some important decisions that will have to be made by the Quality Institute Board. While some members believed it would be appropriate for the Quality Institute to build and maintain (either directly or through a vendor contract) a common database to consolidate all of the quality data in the state and reduce duplicative reporting to various sources, others believed that this would not be the best way to utilize resources. Alternatively, members suggested that the Quality Institute could analyze data sets already collected by various stakeholder groups and identify

[8] For more information, see http://www.dartmouthatlas.org/

additional data sets needed for meaningful and complete analysis of quality. In particular, the group highlighted the need for the Quality Institute to identify opportunities to use and/or develop data sources that provide information about patient experience and measure quality of life and functionality from health care interventions. Members did agree that in its analysis of quality and resource utilization, the Quality Institute will first use administrative data sets, as these are currently available, but that the Institute must acknowledge the limitations of this type of data. The Quality Institute should support efforts of other organizations and clinical societies to develop more robust and representative data sets that are validated, use national benchmarks that are based on prospective, risk-adjusted, physiologic data, and it should utilize these data sets as they become widely available.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the Quality Institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model above).

Members acknowledged the ambitious agenda they established for the Quality Institute and emphasized the need for the Quality Institute Board to prioritize its work based on the quality and transparency goals it sets out for the state. In developing systematic measurements of quality, the Work Group suggested that the Board select particular areas of initial focus, such as the five most prevalent chronic conditions, the integrated health home and/or behavioral health. In addition, members suggested that as the Quality Institute begins its effort to support the provider community in quality improvement, the group should look to expand participation in evidence-based, validated programs that have already been developed and tested by professional associations and organizations. For instance, members highlighted the success of the National Surgical Quality Improvement Program (NSQIP), as an example of a program that has been able to get various stakeholders to collaborate around common quality improvement goals and has been widely tested, validated and benchmarked (See Oregon Chapter of the American College of Surgeons in Appendix A.)

IX. Financing, Structure and Governance

In an attempt to build a framework in which to make decisions about the best governance structure for a Quality Institute, the Work Group determined the following set of criteria:

- Mission – The Institute must have clear and focused mission;

- Stable and adequate funding – The Institute must have long-term core funding from public sources;
- Legislative support – Government must be a leader and a better partner that challenges other stakeholders to join a unified effort to improve quality;
- Unbiased – Stakeholders must be represented in the planning, execution and evaluation processes;
- Legitimacy – The Institute must be trusted by stakeholder groups;
- Accountable – The Institute must be required to measure and demonstrate effectiveness of efforts; and
- Flexibility – The Institute must be able to utilize an efficient and timely decision-making process and have the capacity to drive change.

The Work Group discussed the advantages and disadvantages of various governance models including public, public-private and strictly private models by analyzing the structure, funding and governance of existing organizations within each category. The group ultimately decided that a publicly chartered public-private organization would give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports, and it must provide these same protections to the information submitted by other organizations.

In discussing the makeup of a Board of Directors for the Quality Institute, the Work Group members stressed the importance of limiting the size of the group in order to allow for efficient decision-making. Therefore, the Work Group recommends that the Board be appointed by the Governor and confirmed by the Senate and be comprised of no more than seven members. Members must be committed to and knowledgeable about quality improvement and represent diverse interests (geographic diversity, public/private mix, experts and consumer advocates, etc). In an effort to ensure that a full range of stakeholders are given the opportunity to participate in the work of the Quality Institute, the Board should be able to create stakeholder and technical advisory committees, with chairs of these representative groups serving as ex officio members of the Board. In addition, the group recommends that the Board appoint the Executive Director, to serve at the pleasure of the Board.

In looking at the relationships the Quality Institute would have with other initiatives working to improve quality and transparency, Work Group members attempted to differentiate a number of different approaches the Institute would take in fulfilling its roles. Members agreed that in some cases the Institute would act as a "doer", while in others the Institute would be more likely to act as a "convener", "facilitator" or a "funder". The Quality Institute should act first and foremost as a convener that facilitates "safe table" opportunities for stakeholder groups to collaborate and work

towards consensus on quality-related issues and should be directly involved in setting the quality and transparency policy agenda for Oregon. It is likely that the Quality Institute will often direct, support and fund other organizations in implementing specific initiatives aligned with this agenda, as well as directly carrying out these efforts.

Work Group members agreed that the Quality Institute should be a lean organization, supported by a small professional staff, but that the Institute should partner or contract with a state organization or group with a similar mission to provide human resources, office operations and other administrative support. Members suggested that the Quality Institute explore opportunities to consolidate these functions with the Oregon Patient Safety Commission, Oregon Health Care Quality Corporation or another organization with a mission closely aligned to that of the Quality Institute. However, members noted that if the Quality Institute plans to provide grants and other assistance to outside organizations it would be important for these relationships to be designed in a way that did not create a conflict of interests.

The Work Group stressed the need for state government to provide long-term and sustainable funding for a Quality Institute and to lead other stakeholders in making a robust investment in quality improvement. In addition, nothing would preclude the Quality Institute from seeking additional voluntary funding from private sources to supplement state appropriations. However, Work Group members pointed out that many private stakeholders are already supporting quality improvement organizations and that the Quality Institute should strive to partner with those organizations rather than create parallel and duplicative efforts. The Quality Institute should also be able to receive grants from state and national foundations and agencies, but the Work Group warned that grants alone cannot provide a sustainable or sufficient funding source.

The group estimated that an investment from state government of at least $2.3 million per year over a 10-year period is needed to establish a Quality Institute for Oregon. This budget should be adjusted using the consumer price index or another tool that adjusts for inflation. Appendix C provides budgets for three options for a Quality Institute, one that focuses on data collection and reporting, a second that focuses on convening stakeholders, providing grants and technical assistance and a third combines all of these functions. The Quality Institute Work Group firmly believes that only the third model will provide the infrastructure and support needed to truly drive change and improve the quality and transparency of care delivered to Oregonians.

Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor's Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America's Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes

Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project • Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so that they can ensure patient safety	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be required to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers

Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multi-stakeholder group to define common measures and common expectations of hospital quality ▪ Co-founder, with OMA of Oregon Quality Community	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems
Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals • NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting • ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement initiatives • Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeons
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations

Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by:(1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state(3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers

Oregon Health Policy Commission (OHPC)	The OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is working towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers – Hospitals

Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dialysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers – Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers – Hospitals

Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers

The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

Appendix B: Select State Quality Improvement and Transparency Efforts

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank **–** nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

Maine Health Data Organization ***(MHDO)-*** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

Quality Counts **–** regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

Massachusetts Health Quality Partners ***(MHQP)*** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
    - Taking leadership role in building collaboration and consensus around a common quality agenda
    - Aggregating and disseminating comparable performance data
    - Increasing coordination and reducing inefficiencies to improve quality of care delivery
    - Developing and disseminating guidelines and quality improvement tools
    - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
    - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
        - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

Buyers Health Care Action Group ***(BHCAG) –*** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group,** a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leapfrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public

purchasers (including Minnesota Department of Human Services) that have signed on as "Champions of Change" for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

Minnesota Smart Buy Alliance – voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a "Coalition of Coalitions" – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer's Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:
  - Adopting uniform measures of quality and results
  - Rewarding "best in class" certification
  - Empowering consumers with easy access to information
  - Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

QCare – Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans

- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
    - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
    - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.
    - **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
    - **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
    - **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
    - **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
    - **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done

for complaint information by date, provider type, provider name, and the county or city where the provider is located.

- **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
- **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
- **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
- **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
- **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

Pennsylvania Health Care Cost Containment Council ***(PH4C)*** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through county and state funding, as well as member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment

    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.
- Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

Wisconsin Hospital Association CheckPoint and Price Point – comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
    - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

Wisconsin Health Information Organization (WHIO) - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

Wisconsin Collaborative for Healthcare Quality ***(WCHQ) -*** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

Appendix C: Quality Institute Budget

Assumptions

- The following budgets assume the Quality Institute will have an unpaid voluntary Board of Directors, and voluntary advisory committees as appointed by the Board. The budgets below will have to be adjusted if the state decides the Quality Institute should have a paid Board.
- The Quality Institute will pursue all of the priority roles established in the accompanying report. The budget of the Quality Institute will determine the Institute's ability to pursue a range of other functions.
- The budget allocation for strategic investments will be used to fund projects, in partnership with other quality improvement organization, that align with the mission of the Quality Institute. A significant amount of staff and Quality Institute Board member time will have to be dedicated to developing strategic alliances with other organizations and making transparent decisions about how these dollars can be used to maximize quality improvement across the health care system.

Annual Budget

Operations	
Personnel Costs (lead staff, data analyst, policy analyst, support staff)	$575,000
Software and Infrastructure	$30,000
Roles: Coordination and Collaboration and Policy Advising	
Meeting Costs	$50,000
Roles: Systematic Measurement of Quality	
Vendor Costs (data collection and reporting)	$900,000
Roles: Provider Improvement and Technical Assistance and Consumer Engagement	
Strategic Investments*	$750,000
Total	$2,305,000

The Quality Institute Work Group recommends that the state provide at least $4.6 million per biennium ($2.3 million annually) to establish and operate a Quality Institute able to significantly improve the quality and transparency of Oregon's health care system.

Reference Budgets Consulted
Population of Oregon: 3.7 million

Maine Quality Forum (See Appendix B for full description)

- Budget: MQF has an operating budget of $1 million annually, with administrative and staff salaries funded by the Dirigo Health Authority
- Population of Maine: 1.3 Million (2.4 million less than Oregon)
- Functions: MQF has convening and public reporting functions and advises state government on quality improvement issues. MQF does not directly collect data.

Utah Statewide All Claims Database (as proposed by Utah Department of Health)

- Budget: $1 million annually (includes software costs, vendor contract to clean, merge and maintain data securely and create public reports, one FTE to oversee and manage project and travel)
- Population : 2.6 Million (1.1 million less than Oregon)
- Functions: Create an all-claims database of all medical, pharmacy and dental claims processed for Utah residents and enrollment data for all health plan member. Create public cost and quality reports.

The Pennsylvania Health Care Cost Containment Council (PHC4)

- Budget: Approximately $5 million annually
- Population: 12.4 million (~3 times population of Oregon)
- Functions: Maintains a database of all hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers. Reports data about the cost and quality of health care to public. Studies quality and access issues. Advises state government on quality improvement issues.

Oregon Health Fund Board
Delivery Committee Quality Institute Workgroup Meeting

Friday, March 21, 2008
1:00 – 5:00 pm
Clackamas Community College
Wilsonville Campus Training Center
Rooms 111 and 112
29353 Town Center Loop East
Wilsonville, OR

AGENDA

Time (est)	Item	Lead	Action Items
1:00 pm	**Call to Order and Approval of 3/14 Minutes**	**Vickie Gates**	X
1:10 pm	**Review Work Group Recommendations** **Issues for further discussion:** **-Private funding** **-Role prioritization** **-Alignment with other efforts**	**Vickie Gates**	
3:00 pm	**Break**		
3:15 pm	**Review Work Group Recommendations (cont.)**	**Vickie Gates**	
4:30 pm	**Approve Recommendations with Amendments**	**Vickie Gates**	X
4:50 pm	**Public Testimony**	**Vickie Gates**	
5:00 pm	**Adjourn**	**Vickie Gates**	

OREGON HEALTH FUND BOARD (OHFB)
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORKGROUP

March 14, 2008
1 to 5 PM

Portland State Office Building, Room 1B
800 NE Oregon Street
Portland, OR

MEMBERS PRESENT:	**Vickie Gates, Chair** **Bob Johnson, DMD** **Nancy Clarke** **Jim Dameron** **Gwen Dayton** **Kathy Savicki** **Mike Williams** **Richard Cohen, MD**
MEMBERS EXCUSED:	**Brett Sheppard, MD** **Gil Muñoz** **Maribeth Healey, Vice-Chair** **Maureen Wright, MD** **Ralph Prows, MD** **Glenn Rodríguez, MD**
STAFF PRESENT:	**Jeanene Smith, Administrator, OHPR** **Tina Edlund, Deputy Administrator, OHPR** **Ilana Weinbaum, Policy Analyst** **Zarie Haverkate, Communications Coordinator**
OTHERS ATTENDING:	**Carol Turner, Facilitator**

ISSUES HEARD:

- **Call to Order, Introductions and Approval of 02/05/08 and 02/27/08 Minutes**
- **Review Draft Logic Model**
- **Finalize Quality Institute Roles**
- **Define Details of Governance Structure**
- **Review of Work Group Report Outline**
- **Next Steps**
- **Public Testimony**

Digitally Recorded

Chair Gates

I. Call to order, Introductions and Approval of 2/05/08 and 02/27/08 Minutes (See Exhibit Material 2)

- There is a quorum.
- Review and approval of minutes. Work Group concurred with minutes.
- Chair Gates amends agenda, moving the review of the work group report outline to after the discussion of governance structure.

Chair Gates / Staff **II. Review Draft Logic Model (See Exhibit Material 4)**

- Discussion on funding
  - Change "matching" funds to grants and other funding
  - Discussed need for long-term core funding commitment from the state supplemented by private funding

- Discussion on what body should collect data.
  - Should QI create a common database or analyze datasets collected by other organizations and identify gaps?

- Relationship of QI with other organizations
  - Support good work
  - Get policy buy in – but not always the doer
  - Fund established organizations to do work aligned with QI goals and priorities
  - Synthesizer: listen/feedback/coordination

Chair Gates **III. Finalize Quality Institute Roles (See Exhibit Material 5)**

Underlined statements in document are additions from last meeting.

Overarching Roles
- Discussed need for "statewide leadership".
- Improve health care of Oregonians by focusing efforts on quality, transparency of care.
- Supporting and coordinating existing efforts.

Coordination and Collaboration
- Final bullet - Remove as it is represented in another section.

Systematic Measurement of Quality
- Discussion on the underlined addition to bullet 1, end of first paragraph. Suggest changing to "That supports the use of data for the purpose of health care decision-making and quality improvement."
- Needs clarification that data about providers, health plans and consumer experience should be collected rather than giving the impression that data would be collected from all of these groups.
- Chair Gates addressed the second paragraph on "public disclosure of performance."

Provider Improvement and Technical Assistance
- Discussion on dissemination as stated in bullet 2 and 3.

Consumer Engagement
- Change end of statement from "educate patient" to "engage patient."

Policy Advising

- Suggestion to include examples.
- Discussion on value equation.

Chair Gates **IV. Define Details of Governance Structure**

Reviewed by staff and Committee:

- Hybrid: Public / Private: not virtual, other organizations that can be utilized
- Discussion on specific public and private stakeholders that should be represented on the Board
- Decision that Board should be limited to 7 members that are knowledgeable about and committed to quality improvement and represent diverse stakeholders
- Executive Director should be appointed and serve at the pleasure of the Board

Chair Gates / Staff **V. Review of Work Group Report Outline (See Exhibit Material 3)**

- Staff and the Committee reviewed key pieces of the outline of the work group report.
- Decision that Logic Model should be moved from the end of the report to the after the section on recommendations for an Oregon Quality Institute.

Chair Gates **VI. Next Steps**

- Next meeting on Friday, March 21. Staff will create a draft report and will give members time to comment before final meeting.

Chair Gates **VII. Public Testimony**

No testimony was offered.

Chair Gates **XI. Adjourn**

Meeting adjourned at approximately 5:00 p.m.

Next meeting is March 21, 2008.

Submitted by:
Paula Hird, Office Specialist

Reviewed by:
Ilana Weinbaum, Policy Analyst

EXHIBIT SUMMARY
1. Draft Agenda
2. Draft Minutes from 02/05/08 and 02/27/08
3. QI Report Outline
4. Logic Model
5. Quality Institute Roles

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

March 27, 2008

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Work Group Membership

Vickie Gates, Chair
Health Care Consultant
Oregon Health Policy Commission
Lake Oswego

Maribeth Healey, Vice-Chair
Director
Oregonians for Health Security
Clackamas

Nancy Clarke
Executive Director
Oregon Health Care Quality Corporation
Portland

Richard Cohen, MD
Physician
Grants Pass

Jim Dameron
Administrator
Oregon Patient Safety Commission
Portland

Gwen Dayton
Executive Vice President and Chief Counsel
Oregon Assn. of Hospitals & Health Systems
Lake Oswego

Robert Johnson
Chair
Department of Community Dentistry
OHSU School of Dentistry
Portland

Gil Muñoz
Chief Executive Office
Virginia García Memorial Health Center
Hillsboro

Ralph Prows, MD
Chief Medical Officer
Regence of Oregon
Portland

Glenn Rodríguez, MD
Chief Medical Officer, Oregon Region
Providence Health System
Portland

Kathy Savicki
Clinical Director
Mid-Valley Behavioral Care Network
Salem

Brett C. Sheppard, MD
Professor and Vice-Chairman of Surgery
Oregon Health & Science University
The Digestive Health Center
Pancreatic/Hepato Biliary and Foregut Units
Department of General Surgery
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Maureen Wright, MD
Assistant Regional Medical Director of Quality
Kaiser Permanente Northwest Region
Portland

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Williams Love O'Leary & Powers, P.C.
Portland

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Oregon Health Fund Board — Delivery Systems Committee Quality Institute Workgroup

Report Index

Oregon Health Fund Board — Delivery Systems Committee Quality Institute Workgroup

I. Background

Based on recommendations from the Oregon Health Policy Commission (OHPC), Senate Bill 329 (2007), the Healthy Oregon Act, directs the Administrator of the Office for Oregon Health Policy and Research to develop a model Quality Institute for Oregon as part of the larger health reform planning process established by the bill. The Oregon Health Fund Board assigned this task to the Delivery Systems Committee and chartered a Quality Institute Work Group to develop recommendations regarding the appropriate structure and roles for an Oregon Quality Institute. The Quality Institute would coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery.

The preamble of SB 329 calls for health reform policies that encourage the use of quality services and evidence-based treatments that are appropriate, safe and discourage unnecessary treatment. Research illustrates that the current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over 50 receive recommended preventive care and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[1] In addition, quality of care varies significantly depending on where in the state a patient receives their care, as does the utilization of specific procedures and treatment options.[2] While there are numerous public and private efforts underway across the state to improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and unify existing efforts in the state around quality and transparency.

The availability of clear and transparent information must be the keystone of any health reform plan and any effort to improve the quality of care delivered by Oregon's health care system. The Institute of Medicine's Ten Rules to Redesign and Improve Care calls for shared knowledge and the free flow of information and transparency across the health care system.[3] In addition, President Bush's Four Cornerstones for Healthcare Improvement Executive Order of 2006 calls for greater health system transparency

[1] Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[2] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

[3] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.

through wider availability of health care quality and price data.[4] Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. Therefore, an Oregon Quality Institute is needed to ensure that appropriate and actionable information is available across the health care system and that stakeholders have the tools and knowledge needed to use this information to improve quality of care. A collaborative and well-supported effort to improve quality and increase transparency is a vital part of any effort to transform Oregon's health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

II. Recommendations for a Model Oregon Quality Institute

The Quality Institute Work Group of the Oregon Health Fund Board Delivery Systems Committee recommends the formation of a Quality Institute for Oregon. The group will be established by public charter and structured as a public corporation to give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. The Work Group makes the following recommendations about the structure, governance and funding for a Quality Institute for Oregon.

- A Board of Directors of the Quality Institute will be appointed by the Governor and confirmed by the Senate and include no more than 7 members. Members must be knowledgeable about and committed to quality improvement and represent a diverse constituency. The Board should be supported by advisory committees that represent a full range of stakeholders. The Administrator of the Office for Oregon Health Policy & Research, or a designee, shall serve as an Ex-Officio member of the Board.
- The Quality Institute will have an Executive Director, who is appointed by and serves at the pleasure of the Board. The Quality Institute will have a small professional staff, but should partner or contract with another organization to provide administrative support.
- In order for the Quality Institute to be stable, state government should make a substantial long-term financial investment in the Quality Institute by providing at least $1 million annually for a period of at least 5-10 years. In addition, the Quality Institute will seek additional funding from private stakeholders and grant-making organizations to supplement the state appropriations.

[4] U.S. Department of Health and Human Services, Value-Driven Health Care Home. http://www.hhs.gov/valuedriven/index.html

The Quality Institute's overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission). To achieve its goals, the Quality Institute will:

- Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement.

- Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. ~~Specific emphasis should be placed on endorsing quality measures for primary care medical homes and behavioral health services.~~

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating community guidelines of care and assessing the comparative effectiveness of technologies and procedures.

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

- Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and consumer experience that provides comparable information about quality of care and utilization of health care resources. Data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute will be given the statutory authority to collect data for quality measurement.

- Ensure providers have the ability to produce and access comparable and actionable information about quality and utilization of health care resources that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.

- Support the development ~~and dissemination~~ and facilitate the adoption of health information technology that builds provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. Support efforts to ensure the provider community has the skills to effectively use health information technology to maximize quality of care.

- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

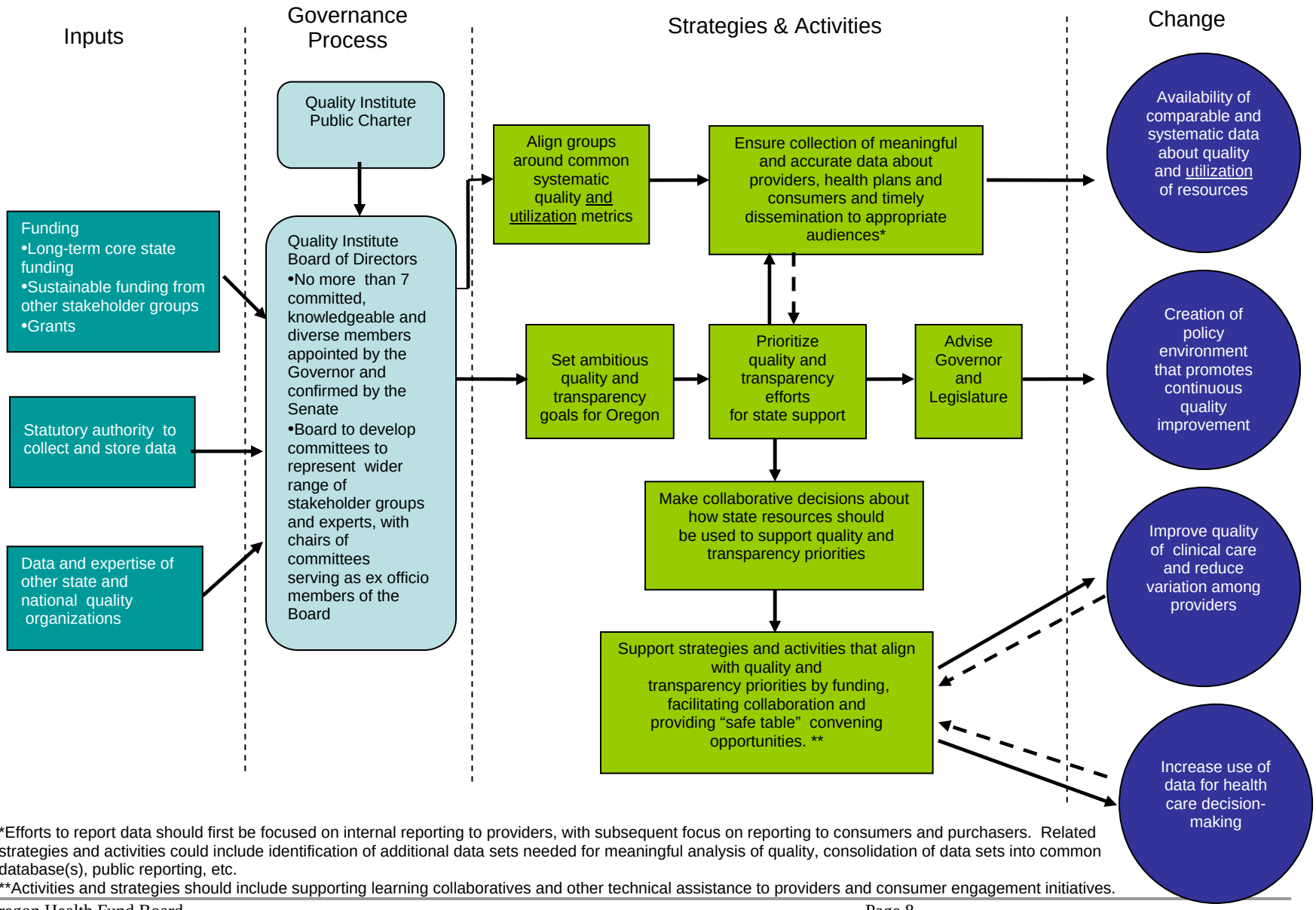
- Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

III. Logic Model for an Oregon Quality Institute

The Quality Institute Work Group constructed a "theory of change" logic model to provide a pictorial representation of its recommendations for an Oregon Quality Institute. The logic model attempts to represent the range of inputs, governance process, strategies and activities the group believes would be required to develop a Quality Institute successful in achieving the following goals:

- Ensure availability of comparable and systematic data about quality and utilization of resources;
- Create a policy environment that promotes continuous quality improvement;
- Improve the quality of clinical care; and
- Increase the use of quality data for health care decision-making.

Logic Model for a Quality Institute for Oregon



*Efforts to report data should first be focused on internal reporting to providers, with subsequent focus on reporting to consumers and purchasers. Related strategies and activities could include identification of additional data sets needed for meaningful analysis of quality, consolidation of data sets into common database(s), public reporting, etc.

**Activities and strategies should include supporting learning collaboratives and other technical assistance to providers and consumer engagement initiatives.

IV. Workgroup Process

The Quality Institute Work Group began their formal deliberations in December of 2007 and held seven meetings. Membership was drawn from a wide range of stakeholder groups and included many of the same people who served on the Oregon Health Policy Commission Quality and Transparency Work Group.

At its first substantive meeting in January 2008, the group was joined by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University, who is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the Work Group's charge, discussed 'Theory of Change' models of behavior change and presented examples and results of quality improvement efforts from around the country. Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings.

In an effort to identify existing gaps in quality and transparency efforts in Oregon and identify possible areas for collaboration and coordination, the work group built on efforts of the Oregon Health Policy Commission Quality and Transparency Work Group to assess the current landscape in Oregon. The following organizations and collaborative initiatives dedicated to quality improvement and transparency were identified and discussed:

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Compare Hospital Costs Website
- Department of Human Services
- The Foundation for Medical Excellence
- Health Insurance Cost Transparency Bill – HB 2213 (2007)
- The Health Care Acquired Infections Advisory Committee
- Independent Practice Associations and Medical Groups
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Community Health Information Network (OCHIN)
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Hospital Quality Indicators
- Oregon IHI 5 Million Lives Network
- Oregon Patient Safety Commission
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance
- Public Employees Benefits Board and Oregon Educators Benefits Board

- Regence Blue Cross Blue Shield

Appendix A provides a matrix which describes these efforts.

The Work Group also examined quality and transparency efforts in other states, focusing on initiatives in Maine, Massachusetts, Minnesota, Pennsylvania, Washington, and Wisconsin. Appendix B provides a description of select quality and transparency efforts in these states.

V. Definitions of "Quality" and "Transparency"

When the Work Group reviewed its charter from the Oregon Health Fund Board at its first meeting, members quickly identified a need to develop standard definitions of *quality* and *transparency*.

Members noted that a number of organizations in Oregon, including the Oregon Health Care Quality Corporation, have incorporated the Institute of Medicine's (IOM) definition of quality, which includes the six domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Members also acknowledged the work of the U.S. Department of Human Services Agency for Healthcare Research and Quality (AHRQ) in the area of quality. On January 3, the Work Group approved the definition of *quality* found below, which combines definitions presented by the IOM and AHRQ.

Quality

As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- **Safe –** avoiding injuries to patients from the care that is intended to help them.
- **Effective –** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered –** providing care that is respectful of and responsive to individual patient preferences needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely –** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient –** avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable –** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

AHRQ has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

The group could not identify a widely accepted definition of *transparency* and had to combine language from various sources with members' best thinking. The concept of "clarity in relationships" was taken from a 2006 article about transparency in health care that appeared in the American Heart Hospital Journal.[5] The Work Group approved the definition below on January 10.

Transparency
A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. ***A transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats.*** This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services (value = quality/cost) provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

VI. Problem Statement

The Quality Institute Work Group also drafted a statement of the problems in the current health care system that could potentially be addressed by an Oregon Quality Institute:

- Need for a robust mechanism to coordinate statewide quality improvement and transparency efforts. Currently, we have:
    - Multiple agencies, organizations, providers and other stakeholder groups furthering quality and transparency efforts, without unifying coordination
    - No mechanism for setting common goals around healthcare quality or a public quality agenda
    - A need for stronger mechanism for sharing of best practices, successes and challenges across efforts
    - Missed opportunities for synergy, efficiency, and economies of scale possible through partnership along common goals
- No comprehensive measurement development and measurement of quality across the health care delivery system

[5] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

  - Consumers and purchasers have limited access to comparable information about cost and quality
  - Providers have limited ability to compare their own performance with peers and to make referral decisions based on quality and cost data
  - Providers are required to report different measures to different health plans and purchasers
- Limited resources dedicated to quality improvement and transparency
  - Lack of resources to support coordination across quality and transparency efforts
  - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
  - Need for systemic mobilization and planning for use of resources in a manner that maximizes system wide impact and reduces duplicative efforts
- Wide variability between providers in quality and cost of care
- Lack of infrastructure (both human and technology) necessary to assess system wide performance and use data to develop a systemic approach to quality improvement
- Lack of systematic feedback and credible data to improve clinical care systems
- Need for new tools to help consumers, purchasers, and providers effectively use data to make treatment and coverage decisions

VII. Assumptions

The Quality Institute Work Group next worked to clarify the starting assumptions that the group would use to identify the appropriate roles and structure of an Oregon Quality Institute for Oregon. The starting assumptions went through a number of iterations and the group approved the set below.

Assumption 1*:* The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality and increase transparency and reduce duplication across stakeholder groups. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and effective, and better able to contain costs.

Assumption 2: The Quality Institute will be an essential element of any sustainable health care reform plan and should play an integral and long-term role in improving quality and increasing transparency across Oregon.

Assumption 3: The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience. These partnerships should be developed in a manner that allows for assessment of the fundamental capabilities of the health care system in Oregon, identification of opportunities to effect change across the system, and monitoring of quality improvement and cost savings from quality improvement across the entire system.

Assumption 4: The Quality Institute will need to be supported by sustainable, stable and sufficient resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system. A broad base of funding, including dedicated public resources and resources from other stakeholders, will be necessary to make progress in quality and transparency.

VIII. Roles of the Quality Institute

The next task for the Quality Institute Work Group was to make recommendations about the appropriate roles of a Quality Institute for Oregon, given the group's problem statement and assumptions. Staff created a draft list of potential roles, based on quality improvement strategies used in other states, as well as other published sources, including the IOM's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.[6] The initial draft list included twelve possible roles, which were categorized using a framework presented by Dennis Scanlon. Each option was categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The facilitator led the group in several rounds of discussion and revision of the role options, with the group analyzing each proposed role, adding additional roles, scoring roles, eliminating roles that were not appropriate for a Quality Institute and combining roles that were redundant. In addition, the group developed a framework for categorizing roles that fall under the auspices of the Quality Institute. The categories the group settled on were *Coordination and Collaboration, Systematic Measurement of Quality, Provider Improvement and Technical Assistance, Consumer Engagement and Policy Advising.*

[6] Institute of Medicine. (2005). Performance Measurement: Accelerating Improvement. National Academies of Press. Washington, D.C.

Overarching Role

The Quality Institute will lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission).

Coordination and Collaboration

- Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement.
- Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. ~~Specific emphasis should be placed on endorsing quality measures for primary care medical homes and behavioral health services.~~
- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating community guidelines of care and assessing the comparative effectiveness of technologies and procedures.
- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

Systematic Measurement of Quality

- Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans, and consumer experience that provides comparable information about quality of care and utilization of health care resources. Data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute will be given the statutory authority to collect data for quality measurement.

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[7]:

- Measures and methodology should be transparent;
- Those being measured should have the opportunity to provide input in measurement systems (not be "surprised") and have opportunities to correct errors;
- Measures should be based on national standards to the greatest extent possible;
- Measures should be meaningful to consumers and reflect a robust dashboard of performance;
- Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting; and
- Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient centered.)

Provider Improvement and Technical Assistance

- Ensure providers have the ability to produce and access comparable and actionable information about quality and utilization of health care resources that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.
- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.
- Support the development ~~and dissemination~~ and facilitate the adoption of health information technology that builds provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. Support efforts to ensure the provider community has the skills to effectively use health information technology to maximize quality of care.

Consumer Engagement

- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

Policy Advising

- Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be

[7] Adopted from the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. For more information, see http://healthcaredisclosure.org.

delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10 year vision, supported by the funding and resources required to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders will need to make a long-term commitment to the goals of improved quality and increased transparency.

In developing recommendations for the appropriate roles for a Quality Institute, the group spent significant time discussing the types of data that would be most useful to stakeholders in assessing quality and driving quality improvement efforts. There was general agreement that cost constitutes one of the potential factors important to the assessment of efficiency. An example considered by the group was the use of generic medication. Cost is part of the value equation (value = quality/cost), but members were aware that it is also a more complex indicator than often realized. Some members cautioned that reporting cost data alone does not provide useful "apples to apples" comparisons, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care. For instance, simply comparing the average price of normal births at two different hospitals would not account for these differences. There were a few members that expressed the view that this information should still be made available with clear explanations of its limitations, but there was general consensus among the members that the Quality Institute should focus on collecting and reporting data directly related to the quality and efficiency of care. The group agreed that an analysis of geographic variations in utilization of health care resources can provide important insight into quality and thus is an appropriate role of a Quality Institute. Members highlighted the value of work done at the Dartmouth Atlas Project in describing variation between hospitals in utilization of resources in the care of Medicare patients.

The Work Group discussed a number of different strategies and activities that the Quality Institute might decide to use to ensure the collection and timely dissemination of systematic data about quality and utilization. While the group decided that the Board of the Quality Institute will determine how best to fulfill this role, the group discussion highlighted some important decisions that will have to be made by the Quality Institute Board. While some members believed it would be appropriate for the Quality Institute to build and maintain (either directly or through a vendor contract) a

common database to consolidate all of the quality data in the state and reduce duplicative reporting to various sources, others believed that this would not be the best way to utilize resources. Alternatively, members suggested that the Quality Institute could analyze data sets already collected by various stakeholder groups and identify additional data sets needed for meaningful and complete analysis of quality. In particular, the group highlighted the need for the Quality Institute to identify opportunities to use and/or develop data sources that provide information about patient experience and measure quality of life and functionality from health care interventions. Members did agree that in its analysis of quality and resource utilization, the Quality Institute will first use administrative data sets, as these are currently available, but that the Institute must acknowledge the limitations of this type of data. The Quality Institute should support efforts of other organizations and clinical societies to develop more robust and representative data sets that are validated, use national benchmarks and are based on prospective, risk-adjusted, physiologic data and should utilize these data sets as they become widely available.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the Quality Institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model above).

Members acknowledged the ambitious agenda it established for the Quality Institute and emphasized the need for the Quality Institute Board to prioritize its work based on the quality and transparency goals it sets out for the state. In developing systematic measurements of quality, the Work Group suggested that the Board select particular areas of initial focus, such as the five most prevalent chronic conditions, the integrated health home and/or behavioral health. In addition, members suggested that as the Quality Institute begins its effort to support the provider community in quality improvement, the group should look to expand participation in evidence-based, validated programs that have already been developed and tested by professional associations and organizations. For instance, members highlighted the success of the National Surgical Quality Improvement Program (NSQIP), as an example of a program that has been able to get various stakeholders to collaborate around common quality improvement goals and has been widely tested, validated and benchmarked (See Oregon Chapter of the American College of Surgeons in Appendix A.)

IX. Financing, Structure and Governance

In attempt to build a framework in which to make decisions about the best governance structure for a Quality Institute, the Work Group determined the following set of criteria:

- Mission – must have clear and focused mission;
- Stable and adequate funding – long-term stable funding must be available from a variety of public and private sources;
- Legislative support – government must be a leader and a better partner that challenges other stakeholders to join a unified effort to improve quality;
- Unbiased – all stakeholders must be represented in the planning, execution and evaluation processes;
- Legitimacy – must be trusted by all stakeholder groups;
- Accountable – must be required to measure and demonstrate effectiveness of efforts; and
- Flexibility – must be able to utilize an efficient and timely decision-making process and have the capacity to drive change.

The Work Group discussed the advantages and disadvantages of various governance models including public, public-private and strictly private models by analyzing the structure, funding and governance of existing organizations within each category. The group ultimately decided that a public corporation with a public charter would give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding.

In discussing the makeup of a Board of Directors for the Quality Institute, the Work Group members stressed the importance of limiting the size of the group in order to allow for efficient decision-making. Therefore, the Work Group recommends that the Board be appointed by the Governor and confirmed by the Senate and be comprised of no more than seven members. Members must be committed to and knowledgeable about quality improvement and represent diverse interests (geographic diversity, public/private mix, experts and consumer advocates, etc). In an effort to ensure that a full range of stakeholders are given the opportunity to participate in the work of the Quality Institute, the Board should be able to create stakeholder and technical advisory committees, with chairs of these representative groups serving as ex officio members of the Board. In addition, the group recommends that the Board appoint the Executive Director, to serve at the pleasure of the Board.

In looking at the relationships the Quality Institute would have with other initiatives working to improve quality and transparency, Work Group members attempted to differentiate a number of different approaches the Institute would take in fulfilling its roles. Members agreed that in some cases the Institute would act as a "doer", while in others the Institute would be more likely to act as a "convener", "facilitator" or a "funder". The Quality Institute should act first and foremost as a convener that

facilitates "safe table" opportunities for stakeholder groups to collaborate and work towards consensus on quality-related issues and should be directly involved in setting the quality and transparency policy agenda for Oregon. At the same time, it is more likely that the Quality Institute will direct, support and fund other organizations in implementing specific initiatives aligned with this agenda, rather than to be directly carrying out these efforts.

Work Group members agreed that the Quality Institute should be a lean organization, supported by a small professional staff, but that the Institute should partner or contract with a state organization or group with a similar mission to provide human resources, office operations and other administrative support. Members suggested that the Quality Institute explore opportunities to consolidate these functions with the Oregon Patient Safety Commission, Oregon Health Care Quality Corporation or another organization with a mission closely aligned to that of the Quality Institute. However, members noted that it would be important for these relationships to be designed in a way that did not create a conflict of interests, if the Quality Institute plans to provide grants and other assistance to outside organizations.

The Work Group stressed the need for state government to provide long-term and sustainable funding for a Quality Institute and to lead other stakeholders in making a robust investment in quality improvement. A successful Quality Institute will require joint public and private funding, with all stakeholders dedicating significant resources to the effort. The Quality Institute should be able to receive grants from state and national foundations and agencies, although the group cautioned that grants alone cannot provide a sustainable or sufficient funding source.

The group estimated that an annual investment from state government of at least $1 million over a 5-10 year period would be needed to support a Quality Institute that could truly drive change and improve the quality and transparency of care delivered to Oregonians. Public funding must be supplemented by private funding from stakeholder groups that benefit from the work of the Quality Institute.

Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor's Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America's Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes

Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project• Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so that they can ensure patient safety	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be required to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers
Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multistakeholder group to define common measures and common expectations of hospital quality	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems

Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals• NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting• ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement intiatives• Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeons
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations
Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers

Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by:(1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state(3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources• Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers
Oregon Health Policy Commission (OHPC)	THe OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is workging towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers

Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers - Hospitals
Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dalysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations

Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers - Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers - Hospitals
Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers

The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers
The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

Appendix B: Select State Quality Improvement and Transparency Efforts

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank **–** nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

***Maine Health Data Organization* (MHDO)-** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

***Quality Counts* –** regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

Massachusetts Health Quality Partners ***(MHQP)*** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
    - Taking leadership role in building collaboration and consensus around a common quality agenda
    - Aggregating and disseminating comparable performance data
    - Increasing coordination and reducing inefficiencies to improve quality of care delivery
    - Developing and disseminating guidelines and quality improvement tools
    - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
    - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
        - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

Buyers Health Care Action Group ***(BHCAG) –*** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group,** a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leafrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public

purchasers (including Minnesota Department of Human Services) that have signed on as "Champions of Change" for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

Minnesota Smart Buy Alliance – voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a "Coalition of Coalitions" – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer's Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:
  - Adopting uniform measures of quality and results
  - Rewarding "best in class" certification
  - Empowering consumers with easy access to information
  - Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

QCare – Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans

- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
    - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
    - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.
    - **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
    - **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
    - **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
    - **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
    - **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done

for complaint information by date, provider type, provider name, and the county or city where the provider is located.

- **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
- **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
- **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
- **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
- **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

Pennsylvania Health Care Cost Containment Council ***(PH4C)*** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through county and state funding, as well as member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment
    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.

- Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

Wisconsin Hospital Association CheckPoint and Price Point – comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
    - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

Wisconsin Health Information Organization (WHIO) - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

Wisconsin Collaborative for Healthcare Quality ***(WCHQ) -*** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

Chart Notes from 3/21/08 Quality Institute Work Group Meeting

Funding

- Pg. 5 – State must make at least $1 million investment per year for at least 10 years to show significant limited long term commitment.
- Added paragraph: QI **may** seek additional funding
- W/robust quality system – get back more bang for buck.
- Leverage other existing work, not duplication of work
- Output = efficiency

Data Collection

- Pg. 6 – QI – That system may be a combination of mandatory and voluntary reporting.
- Collect data about . . . patient experience
- Info about quality of core patient outcomes and utilization of health care resources
- QI – ability to publicize data and supports other organizations publishing data.
- Look at Pg. 14 & 15 – well used publicly available, collaborating
- Add in pt. Outcome last bullet
- Pg. 6 – 3rd bullet, drop "community"

Doer – Supporter

- Pg. 16 – last sentence, it is likely QI will often – as well as directly
- Pg. 16 – add new bullet Provision of health care burden
- Protection / Health oversight. Appropriate confidentiality agreements for Board

Prioritize Roles / Tasks

- Limited resources, ambitious goals
- Pg. 19 – Consolidate and coordinate data (not asking for new data sets). Coordinate, align endorse common measurements
- Pg. 6 – Move bullets to new order. Begin 1, 2, 5, 6, then 4

Medical Home / Behavioral Health

- OK with language on Pg. 17.

Publicly Chartered Organization (vs. Public Corporation)

- State funds
- Liability protection
- Statutory mandate
- Data – confidentiality protection
- Ability to make rules

- Health oversight agency
- Flexible
- Pg. 18 – 2nd bullet – long term state funding
- Unbiased – legitimacy ("all" drop)

Transparency

- What is feasible to make transparent and feasible for providers as one criteria
- Add sentence to 2nd bullet, Pg. 6 – Balancing value of data vs. burden of consolidation (use Acquired Infection language)

QI Relationship to other organizations

- OK with language

Impact / Description of QI

- Overarching role (Pg. 6)
- Will lead to . . . (assumption 1, pg. 12)
- Fundamental / keystone to health care reform – one entity to bring effective efficiency

Debrief on Process

Like:

- Staff work
- Quality / timeliness of work staff work
- New friends!
- Quality of conversation even when disagree
- Facilitation
- Have two co-chairs
- Work with staff in between meetings
- Members responsible for work effort
- Very collaborative effort
- Coordinate to learn from current efforts

To do different next time

- Use video conferencing
- Give more time to digest / focus
- Acknowledge time required to get up to speed
- Access expertise appropriately

Oregon Health Fund Board — Delivery Systems Committee
Quality Institute Workgroup

Report Outline – Draft 3/15

I. Background
   - Background on SB329 and QI Work Group charter
   - Why QI is essential to health reform

II. Recommendations for a Quality Institute for Oregon
   - Structure
   - Roles

III. Workgroup Process
   - Meeting Information
   - Other quality and transparency efforts in Oregon and across the country considered by work group

IV. Definitions of Quality and Transparency

V. Problem Statement

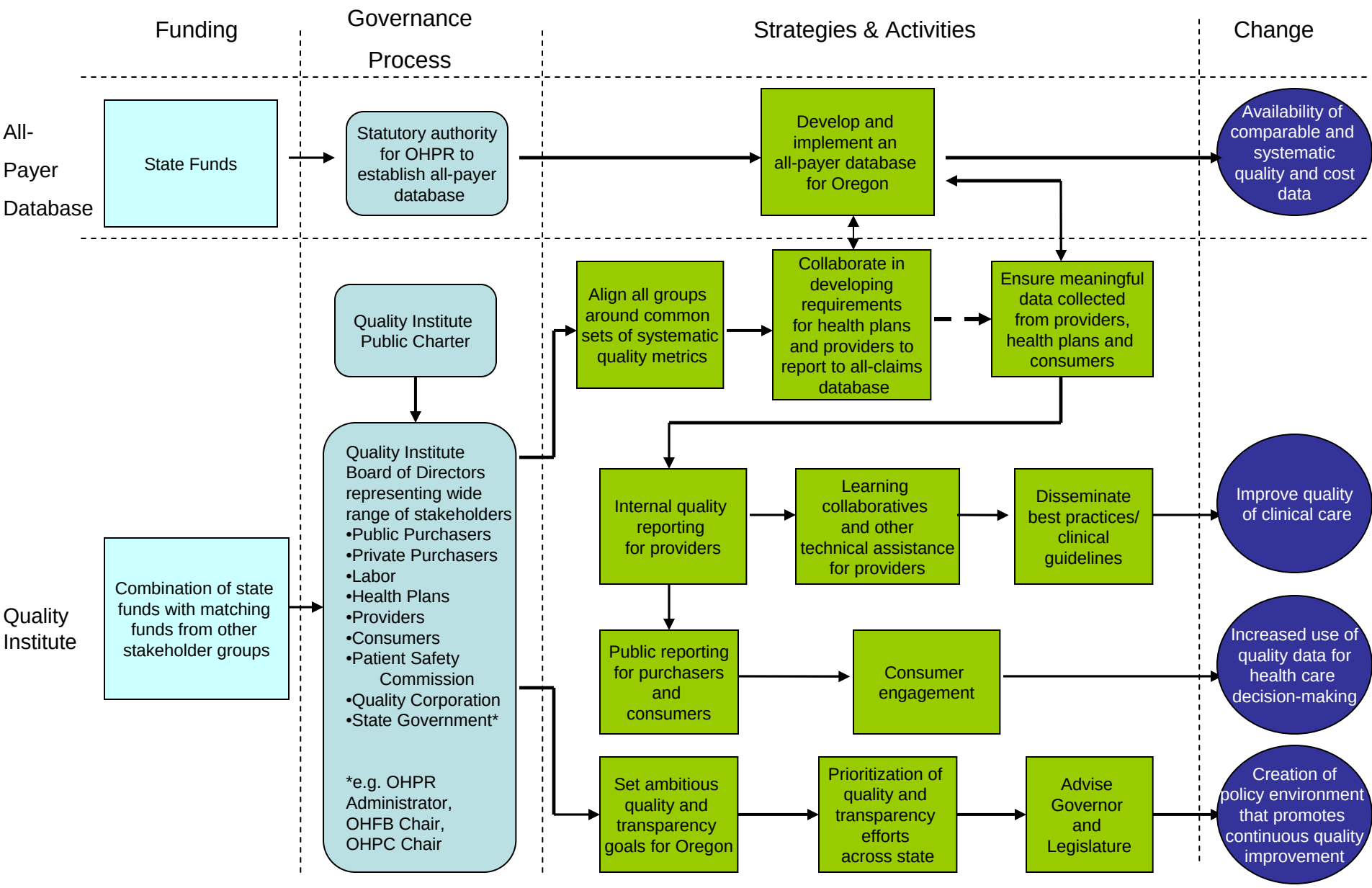
VI. Assumptions

VII. Roles for a Quality Institute
   - Including description of "cost" discussion

VIII. Funding, Structure and Governance

IX. Logic Model

Logic Model for Quality Institute and All-Payer Database – DRAFT 3/14



Quality Institute Roles and Roles Discussion
3/14/08 FOR DISCUSSION ONLY

Overarching Role

The Quality Institute should provide statewide leadership by creating and supporting a unified effort to improve the quality and transparency of health care delivered to Oregonians.

Coordination and Collaboration

- Setting and prioritizing ambitious collaborative goals for Oregon in the areas of quality improvement and transparency. Progress towards achieving these goals should be measured and reported and goals should be adapted and updated to encourage continuous improvement.
- Convene public and private stakeholders to align all groups around common sets of quality metrics for a full range of health care services. Metrics adopted for Oregon should be aligned with nationally accepted measures that make sense for Oregon. Specific emphasis should be placed on endorsing quality measures for primary care medical homes and behavioral health services.
- Participate in development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects, including those that explore opportunities to provide incentives for quality improvement.
- Gaining consensus across stakeholder groups on evidence-based practices and clinical standards. Clinical guidelines and best practices should be widely disseminated.

Systematic Measurement of Quality

- Ensure meaningful and accurate data about quality and costs associated with quality is collected from providers, health plans and consumers in a timely manner and disseminated in appropriate formats to various target audiences (right information to the right people). Data should be easily accessible to health care purchasers, accountable health plans, and other members of the public in formats that support the use of data for the purpose of value-based purchasing and other health care decision-making.

  When developing a system and methods for public disclosure of performance of information, the Quality Institute should consider the following criteria (borrowed from the consumer-purchaser disclosure project):
  - Measures and methodology should be transparent
  - Those being measured should have the opportunity to provide input in measurement systems, not be "surprised) and have opportunities to correct errors

- Measures should be based on national standards to the greatest extent possible
- Measures should be meaningful to consumers and reflect a robust dashboard of performance
- Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting
- Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient centered.)

Provider Improvement and Technical Assistance

- Ensure providers have the ability to produce and access to comparable and actionable information about cost and quality that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.
- Convene learning collaboratives and provide other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Broadly disseminate proven strategies of quality improvement.
- Support the development and dissemination and facilitate adoption of health information technology that builds provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. Ensure provider community has the skills to effectively use health information technology to maximize quality of care.

Consumer Engagement

- Support efforts, in partnership with providers, to engage consumers in the use of quality and cost data and evidence-based guidelines to make health decisions and educate patients about the importance of taking responsibility for their own health.

Policy Advising

- Advise Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency.

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10 year vision with the funding required to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the

Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders, will need to make a long-term commitment to the goals of improved quality and increased transparency.

The group was able to gain general consensus about the important roles of an Oregon Healthcare Quality Institute, with one notable exception. A number of members expressed significant concern regarding the role of the Quality Institute in collecting and/or reporting cost data. There was general agreement that cost is inherent in efficiency, which is included in the group's definition of quality, and that cost is a part of the value equation (value = quality/cost). However, a number of members expressed the view that the Quality Institute should focus primarily on collecting, analyzing and reporting quality data and cost data only when it is directly associated with quality and efficiency. These members were concerned that data about the cost of delivering care is often unrelated to quality of care and that collecting and analyzing such data should be left to another group. Members discussed the limitations of current methodology surrounding health care cost data and the difficulty in producing useful information that provides "apples to apples" comparisons. These members expressed concern that cost data is difficult to interpret, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care.

Other members expressed that despite current limitations, cost is an important dimension of the value equation and that the Quality Institute would be doing stakeholder groups a disservice if it did not consider cost data in its work. These members reflected on the desire of both purchasers and consumers to better understand and have better information about the cost of care. Members agreed that reporting of cost data should be accompanied by information about the limitations of such data, but that it was still important for the Quality Institute to develop the methodologies and tools necessary to improve transparency around both cost and quality.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the quality institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model below).

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The Oregon Health Fund Board
Delivery System Committee Quality Institute Work Group
Vision for Health Care Quality and Transparency in Oregon
Approved 1/10/08

The Quality Institute Work Group of the Oregon Health Fund Board Delivery System Committee seeks to develop strategies to create a high-quality and highly transparent health care system in Oregon.

The work group endorses the following definitions of "quality" and "transparent:"

Quality
As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- Safe – avoiding injuries to patients from the care that is intended to help them.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered – providing care that is respectful of and responsive to individual patient preferences needs, and values and ensuring that patient values guide all clinical decisions.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The Agency for Healthcare Research and Quality has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

Transparent

A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. A transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats. This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

OREGON HEALTH FUND BOARD (OHFB)
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORK GROUP
Flip Chart Notes 1/10/08

DRAFT ASSUMPTIONS

- Main Function of QI to coordinate, strengthen and supplement current and ongoing quality improvement and transparency underway in state.

  Discussion:
  - Meaning of state? Fixing everything in Oregon, across Oregon, NOT state government
  - Current? How relate to future? Ongoing should be included
  - Establish goals of QI and transparency as role of QI
  - Strengthen: force for change, advocacy, financial support
  - Owned by state entity
  - Scope – input under reform or bigger around health care quality?
  - Tensions – scope and government
  - Possible role for QI missing for assumption: ongoing role for QI to make recommendations for policy change? What would be the mechanism to inform state policy?
    - Mechanism to inform – state policies – is this role?
  - Should include transparency efforts
  - Create systemness across state
  - Should look at absolutely needed, good to include and what would be included in dream world
  - Part of reform movement but should be part of ongoing improvement
  - Can't reform what can't measure – data measurement and collection; IT systems; info as levers for reform not recommendation for reform

- ~~Unique history/composition~~ Strengthen (or strength of) ~~of~~ stakeholders requires a range of strategies to further quality and transparency agenda – market based, provider collaboration, consumer engagement and regulatory approaches.
  - Is transparency a separate goal?
  - May be other strategies not listed
  - Unique history – what are difference between OR and other states? Diff perspectives? Unique starting point – coming from legislative process
  - Clarification – unique relates to history and organizations (specific govt organizations, stakeholders in play), not the measures that will be used or the work/strategies – QI should build on national work; need to recognize environment and develop QI in context of OR situation
  - Individual efforts, various organizations, might use different strategies
  - QI itself may not use all strategies, but stakeholders will
  - Who owns levers for change?
  - ?? about regulatory authority of QI – not a regulatory agent, but may take recommendations to state agencies with regulatory authority
  - How to collaborate and make parts a whole
  - Recommendation – collaborative nature, capitalize on variety of strategies
  - Respond to charge – develop recommendations for model QI.
  - Narrow roles: central repository, evaluate reform effort and allow measurement; at minimum should measure and report, allowing for better aggregation
    - Statute language includes HIT as basic pieces, necessary for good measurement
  - Wider roles: champion of quality improvement, analysis, goal setting (is duplicative of what already happening?
  - What is role in more effective health care system

- Necessary for ~~(synergestic)~~ collaboration among all stakeholders around common goals will maximize efficient use of resources and eliminate duplicative, as well as help build consensus

among various stakeholders about what effort will be most effective in increasing quality and transparency of care delivered to Oregonians.
    - Replace synergistic
    - Collaboration → synergy → theory of change
    - Goal rather than assumption? Represents goal of what trying to achieve – not easy to get there
    - Good faith collaboration necessary
    - Need resources to strengthen collaboration, including staff to make collaboration work. Must provide help to achieve own individual goals, as well as group goals. If no intent to give resourced, no added value.
    - Assumption: resources are going to be available.
    - Development of Common goals: Common goals created through collaboration/alignment of future goals → Where to dedicate $$ (money)
    - How does quality fit into redesigned delivery system? Quality should be front and center.
    - Define what – best practices
    - What vision for the future – what do need to get there?
    - Statute doesn't talk about use of data for quality improvement
    - Statute as minimum requirements – should also do gap analysis of what state needs

- Collaboration around QI will lead to a high quality system that is safer, more effective, patient-centered, timely, efficient and effective, and better able to contain costs.
    - Definition of quality – should be wrapped into other assumptions

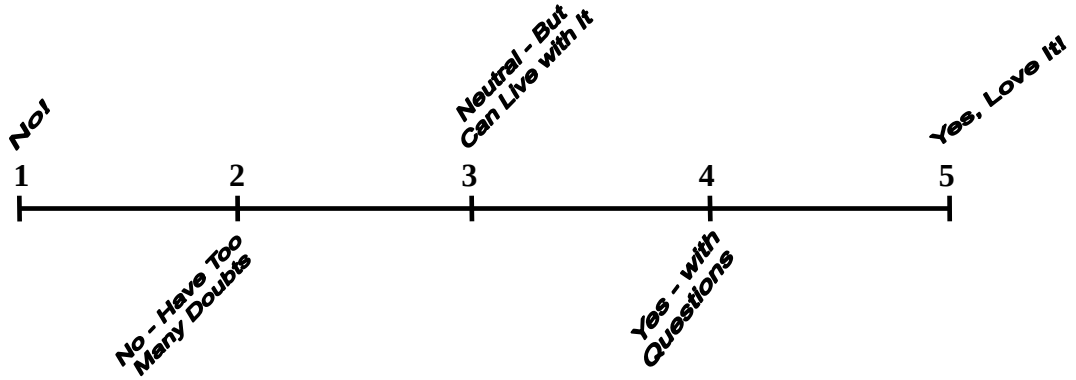
- (Added) Necessary to be backed by adequate resources

Others
- virtual vs. bricks and mortar?
- Agent of change
- QI drives reform or ongoing effort to improve quality across state? Statute – bigger than just reform
- In order to reform, must have _____ in place.

ROLES FOR QUALITY INSTITUTE

Questions Re: Potential Roles

1. **Is this role clear? Clarify words/phrases?**
2. **What excites you about this potential role?**
3. **The challenge(s) with this role is . . .**
4. **What other organizations/efforts are working this area (besides matrix)**



A. (Nancy Bret, Maureen) Setting ambitious collaborative goals for Oregon in the areas of quality improvement and transparency. Progress towards achieving these goals should be measured and reported and goals should be adapted and updated to encourage continuous improvement.

1. Yes
2. Encourages priority setting about what really matters
    - helps define where the quality groups overlap or don't/AND miss or are uniquely working
    - establishes a necessity to prioritize
3. Difficult to prioritize
    - concern about unfunded mandates, raise expectations and cannot follow through
    - Who decides on what criteria and how does that mesh with others' mandatory priorities?
    - Consumers' point of view bigger than clinical quality
4. National New Group above NQF (!)? Revitalization of primary care – referring out

Vote – 5 (8)
4 (1)

B. (Nancy Bret, Maureen) Overseeing the development of quality measures for a full range of health care services. It should convene public and private stakeholders to develop (or endorse) standard sets of measures to be used across the state. Specific emphasis should be placed on developing a unique set of quality measures for primary care medical homes and behavioral health services

1. Needs to be rewritten – the states role is to align, adopt, apply national metrics
2. Nothing
3. This is wrong
4. NQF and others are creating and developing standard metrics.

Vote for re-write – 5 (7)
4 (1)
2 (1) – this was from Gwen, who wasn't voting on re-write but on given role statement

C. (Nancy, Brett, Maureen) Ensuring data is collected from providers and health plans in a timely manner and disseminated in appropriate formats to various target audiences. Clinic level information about provider performance should be made easily accessible to health care purchasers and other members of the public

1. Role is clear
    - Add: providers mean across continuum – providers, health plans, consumers, etc.
    - Reword: Clarify that we also want providers themselves to have the data to improve
    - Add adjectives accurate and meaningful to data
    - Clarify that data must provide useful/actionable information
    - The right people get the right information (Doctor level, clinic level, etc.)
2. On the road to be able to compare apples to apples and find and promote the best
    - You can lift the worst performers to improve with information ↓↓ unnecessary variation
    - It's what the public wants and needs allow to regain public trust
    - Needs processes standards
3. Currently <u>terribly</u> under-funded
    - Getting hardware and systems, as well as ability to do meaningful analysis and use analysis to drive change - its very hard to do software analysis

- Look at carrots/sticks

Vote – 5 (6)
4 (2)
3 (1)

D. (Jeanene, Gwen) Ensure providers have access to information about cost and quality that allows them compare performance against other providers and create data-driven quality improvement programs. Convene learning collaboratives and provide other technical assistance for providers to develop and share best practices.

1. Role clear? Okay with concept: ensure access to comparable data. Make sure right info to right folks in timely manner
2. What excites? Not just collect, but use to educate, Δ (change) care practices
3. Challenges? "lots" re comparison (comparing apples to applies)
   - need funding for tech assistance
   - ? liability issues/discoverability
4. Who else is working on this?
   - hospital data – hospital assoc. (quality, costs and charges), the state (OHPR hospital quality analysis input)
   - Quality corp – common measures/RWJF aligning forces
   - CareOregon – learning collaboratives for their grantees
   - OHSU – D. Dorr – tech assist to a set of providers (via a grant)

Vote – 5 (6)
4 (3)

E. (Jeanene, Gwen) Develop and test new quality improvement strategies by coordinating and/or funding quality improvement demonstration projects.

1. Role clear? does it fit in one of the buckets?
   - Champion?
   - Projects?
2. What excites? "lots"
3. Challenges?
   - consider for legal issues
   - need for adequate funding – use of research funding
   - need process/staff to develop, coordinate
4. Who else is working on this?
   - Health plans, i.e. Regence + CareOregon
   - Hospital Association + OMA

Vote – 5 (4)
4 (1)
3 (2)
2.5 (1)
2 (1)

F. (Jim, Maribeth) Supporting the development and diffusion of interoperable health information technology to ensure that the right information is available at the right time to patients, providers, and payers.

1. Role clear? Yes. Vague about "support."
2. What excites?
   - Ability to reduce errors
   - Better care

- Save $ (?)
- Time is now: joint ??
- Idea needs independent owner

3. Challenges?
    - Privacy
    - Infrastructure costs
    - Who pays/who benefits
4. Who else is working on this?
    - Q – Corp . . .
    - Gov office HIIAC

Vote – 5 (3)
4 (3)
3 (2)
2 (1)

G. (Jim, Maribeth) Encouraging the development (and/or endorsement) and dissemination of clinical guidelines and evidence-based policies that encourage more effective use of medical technology and clinical procedures, starting with conditions and procedures that are most predominant and costly in the state.

1. Role clear? Yes
    - Encouraging?
2. What excites? A little.
    - eliminate needless variation
    - science based
    - independent clearing house – ICSI
    - opportunity to identify priorities of high resource benefit
3. Challenges?
    - Changing behavior
    - Too many actors
    - Labor intensive?
4. Who else is working on this?
    - What bucket? Different efforts - need for uniformity

Vote – 5 (4)
4 (3)
3 (1)
2 (1)

H. (Gil, Vickie) Encouraging providers to engage patients in shared-decision making by promoting the use of patient decision aids.

1. Role clear? No.
    - Is this Dartmouth inspired?
    - Preference sensitive
    - what kinds of aids?
2. What excites? Maybe.
    - Patient engagement and supporting patient decisions import – right for QI?
    - Dissemination of evidence base/best practice
3. Who else is working on this?
    - Health plans
    - Medical groups
    - Purchasers requiring or encouraging TA groups – TFME, professional associations
4. Challenges?
    - requires redesign

- physician attitudes
- Few resources – intellectual and evidence leader

(Consumer engagement proposed as add on came from this discussion)

Vote – 4 (1)
3 (1)
2 (2)
1 (5)

I. (Gil, Vickie) Seeking opportunities to reward providers who deliver high-value care to their patients by using information about cost, quality and provider performance to drive changes in reimbursement policies.

1. Role clear? Institute's role not clear
   - Think tank/convener
   - Encourage/link best practice - new demos
   - Evaluation
2. Excitement – exciting area to consider how to promote and reward quality
   - Shifts incentives to prevention
3. Challenges?
   - Is this most effective to change? other ways such as:
     - IT infrastructure grants
     - Training
     - Best practice forum
   - Sustainability
   - Shape evidence on what works best
   - $$ for pilots and evaluation
4. Who else is working on this?
   - State/ National experiments
   - Purchasers
   - Health plans
   - Bridges to Excellence
   - California effort

Votes – 5 (3)
4 (3)
3 (1)
1 (2)

J. (Jim, Maribeth) Building on state value-based purchasing efforts and encourage private purchasers to incorporate quality and cost data into purchasing decisions.

1. Role clear? Which efforts? PEBB? Medicaid? Public? Private? Both?
2. What excites?
   - Saving $$/RQI helping
   - Purchasers finding their power
3. Challenges?
   - Atomized
   - Lack of information – What is Quality?
   - Lack of resources to staff the work.

Votes – 4 (3)
3 (3)
2 (3)
One of the 3 votes was for a 5 if applied to plans under SB 329

K. (Mike, Ralph) Develop requirements for health plans that tier providers and/or build provider networks to ensure processes are transparent and quality of care considered along with cost.

1. Role clear? Yes, though "process" = vague, "draft regulations" vs. "requirements"
2. What excites?
   - Might mitigate litigation
   - Promote openness
   - Promote acceptance/validity → activation
3. Challenges?
   - If done poorly → increase litigation. In scope?
4. Who else is working on this?
   - Q Corp
   - Most HP's
   - Local providers
   - Community based/phys. driven

Scope Issue : QI promote openness. QI recommends regulations? Concern about promoting (increasing) litigation of regulations?

Vote – 4 (1)
3 (1)
2 (3)
1 (4)

L. (Mike, Ralph) Advise Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency (e.g. No payment for "never events", requirements on insurers to report claims data)

1. Role clear? yes
2. What excites?
   - Stay on top of best practices and develop OR-specific recommendations
   - Somebody ought to do this!
   - QI think tank here – Central place
3. Challenges? Resources
4. Who else is working on this?
   - Pat safe comm.
   - Health Policy Commission
   - OHPR
   - OHSU – EBM
   - Professional Assns.
   - Health plans.
   - No central place

Take out examples!!

Vote – 5 (8)
4 (1)

<u>Additional</u>

Learning Communities and Technical Assistance: Vote – 5(2), 4(5), 3(2)

Referral/Interface w/ public health issues: Vote – 5(5), 4(2), 3(1)

Patient Education, Engagement – Inform, evidence-based: Vote – 5(5), 4(4)

OREGON HEALTH FUND BOARD (OHFB)
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORK GROUP
Revised Assumptions 2/5/08

DRAFT ASSUMPTIONS

- The main function of the Quality Institute will be to coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality and increase transparency. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and effective, and better able to contain costs.

- The Quality Institute will be established as part of a larger health care reform, and should play an ongoing and integral role in improving quality and increasing transparency across Oregon.

- The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience.

- Good faith collaboration among all stakeholders will be necessary to maximize efficient use of resources and eliminate duplicative efforts, as well as to help build consensus among various stakeholders about what efforts will be most effective in increasing the quality and transparency of care delivered to Oregonians.

- The Quality Institute will need to be supported by adequate resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system.

Oregon Health Fund Board
Delivery Systems Committee Quality Institute Workgroup
***DRAFT* Problem Statement**
2/5/2008

The Quality Institute Work Group has identified the following problems that could be addressed by a quality institute:

- No mechanism for statewide coordination
    - Multiple agencies, organizations and groups furthering quality and transparency efforts, without unifying coordination
    - No mechanism for setting common goals/agenda or reducing duplicative efforts
    - No mechanism for sharing of best practices, successes and challenges across efforts
- No common reporting requirements/measurements across purchasers and health plans
    - Consumers and purchasers have limited access to comparable information about cost and quality
    - Providers have limited ability to compare own performance with peers and to make referral decisions based on quality and cost data
    - Providers required to report different measures to different health plans and purchasers
- Limited resources
    - Lack of resources to support coordination across quality and transparency efforts
    - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
- Wide variability between providers in quality and cost of care
- Lack of training for providers, purchasers, consumers to effectively use data to make treatment decisions and develop quality improvement initiatives

Updated and Scored Roles for Quality Institute
For Discussion Only 2/5/08

(Note: The scoring is on a 1-5 scale, with 1 indicating definite lack of support for the proposed role and 5 indicating high support for the proposed role.)

Coordination and Collaboration

- Setting ambitious collaborative goals for Oregon in the areas of quality improvement and transparency. Progress towards achieving these goals should be measured and reported and goals should be adapted and updated to encourage continuous improvement.
  5(8), 4(1)

- Convene public and private stakeholders to align all groups around common sets of quality metrics for a full range of health care services. Metrics adopted for Oregon should be based on nationally accepted measures. Specific emphasis should be placed on endorsing quality measures for primary care medical homes and behavioral health services.
  5(7), 4(1), 2(1)

- Participate in development and assessment of new quality improvement strategies by championing, coordinating and/or funding quality improvement demonstration and pilot projects.
  5(4), 4(1), 3(2), 2.5(1), 2(1)

- Coordinate an effort to develop (and/or endorse) and disseminate clinical guidelines and evidence-based policies that encourage more effective use of medical technology and clinical procedures, starting with conditions and procedures that are most predominant and costly in the state.
  5(4), 4(3), 3(1), 2(1)

Value-Based Purchasing

- Ensure meaningful and accurate data about cost and quality is collected from providers, health plans and consumers in a timely manner and disseminated in appropriate formats to various target audiences (right information to the right people). Data should be easily accessible to health care purchasers and other members of the public.
  5(6), 4(2), 3(1)

- Build on state value-based purchasing efforts and encourage private purchasers to incorporate quality and cost data into purchasing decisions.
  4(3), 3(3), 2(3)
  One of the 3 votes was for a 5 if applied to plans under SB 329

- Fund demonstration projects and evaluations and/or coordinate learning collaboratives to encourage purchasers to develop reimbursement policies that use information about cost, quality and provider performance to reward high-value providers.
  5(3), 4(3), 3(1), 1(2)

- Make recommendations for requirements for health plans that tier providers and/or build provider networks to ensure processes are transparent and quality of care considered along with cost.
  4(1), 3(1), 2(3), 1(4)

Provider Improvement and Technical Assistance

- Ensure providers have access to comparable and actionable information about cost and quality that allows for comparison of performance and creation of data-driven quality improvement initiatives.
  5(6), 4 (3)

- Convene learning collaboratives and provide other technical assistance for providers to develop and share best practices for using data to drive quality improvement.
  5(2), 4(5), 3(2)

- Support the development and diffusion of interoperable health information technology to build provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers.
  5 (3), 4 (3), 3 (2), 2 (1)

Consumer Engagement

- Encourage providers to engage patients in shared-decision making by promoting the use of patient decision aids.
  4 (1), 3(1), 2(2), 1(5)

- Support efforts to engage and educate patients about the importance of using quality and cost data and evidence-based guidelines to make care decisions.
  5(5), 4(4)

Policy Advisement

- Advise Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency.
  5(8), 4(1)

- Interface with public health agencies to maximize potential of quality and transparency efforts to improve overall population health.
  5(5), 4(2), 3(1)

The Oregon Health Fund Board
Delivery System Committee Quality Institute Work Group
Definition of Transparent
Draft 1/10/08

Transparent

A transparent health care system provides clarity in relationships between patients, providers, insurers and purchasers of health care. A transparent system makes information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats. This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services provided and giving providers the tools and information necessary to compare their performance against the performance of other providers. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

Quality and Transparency Language in SB 329
Quality Institute Work Group Meeting
1/10/2008

Language Directly Related to Quality Institute

Section 13(2). The administrator [of OHPR] shall develop recommendations for a model quality institute that shall:
(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;
(b) Provide leadership and support to further the development of widespread and shared electronic health records;
(c) Develop the capacity of the workforce to capitalize on health information technology;
(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;
(e) Support the Oregon Patient Safety Commission′s efforts to increase collaboration and state leadership to improve health care safety; and
(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

Other Quality and Transparency Language

Preamble:

- Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment
- Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable

Section 3. The Oregon Health Fund program shall be based on the following principles:
(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

Section 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan that meets the intended goals of the program to:

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost
(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market
(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home
(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.

Section 9(2)(b) [The Delivery Committee shall develop proposals that address] Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:
(B) The proposal must ensure that each accountable health plan:
(v)Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;
(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure.
(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;
(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

Section 13(1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act [comprehensive reform plan]. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:
(a) Access to care;
(b) Access to health insurance coverage;
(c) Quality of care;
(d) Consumer satisfaction;

(e) Health status;
(f) Provider capacity;
(g) Population demand;
(h) Provider and consumer participation;
(i) Utilization patterns;
(j) Health outcomes;
(k) Health disparities;
(L) Financial impacts, including impacts on medical debt;
(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;
(n) Impacts on the financing of health care and uncompensated care;
(o) Adverse selection, including migration to Oregon primarily for access to health care;
(p) Use of technology;
(q) Transparency of costs; and
(r) Impact on health care costs.

The Oregon Health Fund Board
Delivery System Committee Quality Institute Work Group
Starting Assumptions
Draft for Discussion 1/10/08

The Quality Institute Work Group will analyze policy options to determine the degree to which alternative models have the potential to move the health care system in Oregon toward higher quality and transparency. The Work Group is starting with the following assumptions:

- **The main function of the "Quality Institute" will be to coordinate, strengthen and supplement current quality improvement efforts currently underway across the state.**
- **The unique history and composition of stakeholders requires that a range of strategies will need to be utilized to further the quality agenda, including market-based, provider collaboration, consumer engagement and regulatory approaches.**
- **Synergistic collaboration among all stakeholders around common goals will maximize the efficient use of resources and eliminate duplicative efforts, as well as help to build consensus among various stakeholders about what efforts will be most effective in increasing quality and transparency of care delivered to Oregonians.**
- **Collaboration around quality improvement will lead to a high quality system that is safer, more effective, patient-centered, timely, efficient and effective and better able to contain costs.**

The Oregon Health Fund Board
Delivery System Committee Quality Institute Work Group
Potential Roles for a Quality "Institute" for Oregon
Draft for Discussion 1/10/08

This document is drafted by staff as a straw person proposal of the potential roles for a Quality Institute in Oregon. Staff developed this document from various sources, including the Institute of Medicine's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.

The options below are categorized using a framework presented by Dennis Scanlon, evaluator of the Robert Wood Johnson Foundation "Aligning Forces for Quality" grant program. Each option is categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The Quality Institute Work Group proposes a model "Quality Institute" that will take on the following functions:

A. Setting ambitious collaborative goals for Oregon in the areas of quality improvement and transparency. Progress towards achieving these goals should be measured and reported and goals should be adapted and updated to encourage continuous improvement.
   - Primary Strategy – Collaborative Quality Improvement Approach
   - Domains: All
   - Target Audience: All Stakeholders

B. Overseeing the development of quality measures for a full range of health care services. It should convene public and private stakeholders to develop (or endorse) standard sets of measures to be used across the state. Specific emphasis should be placed on developing a unique set of quality measures for primary care medical homes and behavioral health services
   - Primary Strategy - Market-based approach
   - Domains: All (would have to determine focus)
   - Target Audience: Providers, Purchasers

C. Ensuring data is collected from providers and health plans in a timely manner and disseminated in appropriate formats to various target audiences. Clinic level information about provider performance should be made easily accessible to health care purchasers and other members of the public
   - Primary Strategy – Market-based approach
   - Domains: All (would have to determine focus)
   - Target Audience: Patients/Consumers

D. Ensure providers have access to information about cost and quality that allows them compare performance against other providers and create data-driven quality improvement programs. Convene learning

collaboratives and provide other technical assistance for providers to develop and share best practices.
- Primary Strategy – Collaborative quality improvement approach
- Domains: All (would have to determine focus)
- Target Audience: Providers

E. Develop and test new quality improvement strategies by coordinating and/or funding quality improvement demonstration projects.
- Primary Strategy – Collaborative quality improvement approach
- Domains: All (would have to determine focus)
- Target Audiences: Providers, Health Plans, Consumers

F. Supporting the development and diffusion of interoperable health information technology to ensure that the right information is available at the right time to patients, providers, and payers.
- Primary Strategy: Market-based approach, Collaborative quality improvement approach
- Domains: All
- Target Audience: Consumers, Providers, Health Plans

G. Encouraging the development (and/or endorsement) and dissemination of clinical guidelines and evidence-based policies that encourage more effective use of medical technology and clinical procedures, starting with conditions and procedures that are most predominant and costly in the state.
- Primary strategy: Collaborative quality improvement approach
- Domain: Effectiveness - provision of evidence-based care
- Target Audience: Providers

H. Encouraging providers to engage patients in shared-decision making by promoting the use of patient decision aids.
- Primary strategy – Consumer/Patient Engagement
- Domain: Patient-centeredness, Effectiveness
- Target Audience: Consumers, Providers

I. Seeking opportunities to reward providers who deliver high-value care to their patients by using information about cost, quality and provider performance to drive changes in reimbursement policies.
- Primary Strategy – Market Based Approach
- Domain: All (would have to select focus)
- Target Audience: Providers

J. Building on state value-based purchasing efforts and encourage private purchasers to incorporate quality and cost data into purchasing decisions.
- Primary strategy – Market-based approach
- Domain: All (would have to select focus)
- Target audience: Purchasers

K. Develop requirements for health plans that tier providers and/or build provider networks to ensure processes are transparent and quality of care considered along with cost.
- Primary strategy: Regulatory approach
- Domain: All
- Target audience: Health plans

L. Advise Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency (e.g. No payment for "never events", requirements on insurers to report claims data)
- Primary strategy – Regulatory
- Domain – All (would have to select focus)
- Target audiences: Providers, Insurers

DISCUSSION DOCUMENT

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor's Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America's Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes
Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project • Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be requierd to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers
Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multistakeholder group to define common measures and common expectations of hospital quality	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals • NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting • ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement intiatives • Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeo
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations
Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
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Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by: (1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state (3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers
Oregon Health Policy Commission (OHPC)	THe OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is workging towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers - Hospitals
Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dalysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers - Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers - Hospitals

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health

APPENDIX A: Organizations Categorized by Major Functions

Data Collection Function

- Compare Hospital Costs Web Site
- Department of Human Services
- The Health Care Acquired Infection Advisory Committee
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Health Quality Corporation
- Oregon Hospital Quality Indicators
- Oregon Patient Safety Commission
- Public Employees Benefits Board
- Regence Blue Cross Blue Shield

Public Reporting Function

- Compare Hospital Costs Web Site
- Oregon Association of Hospitals and Health Systems
- Oregon Hospital Quality Indicators
- HB 2213 (2007) – Health Insurance Cost Transparency Bill
- The Health Care Acquired Infection Advisory Committee

Reporting to Providers to Support Quality Improvement

- Department of Human Services
- The Health Care Acquired Infection Advisory Committee
- Oregon Chapter of the American College of Surgeons
- Oregon Patient Safety Commission
- Regence Blue Cross Blue Shield
- Oregon Association of Hospitals and Health Systems
- Oregon Coalition of Health Care Purchasers
- Oregon Health Care Quality Corporation

Quality Improvement Education/ Support/Technical Assistance to Providers

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Department of Human Services (DHS)
- The Foundation for Medical Excellence
- Oregon Association of Hospitals and Health Systems
- Oregon Community Health Information Network
- Oregon Health and Sciences University Medical Informatics
- Oregon IHI 5 Million Lives Network
- Oregon Primary Care Association
- Oregon Quality Community
- Oregon Health Care Quality Corporation
- Oregon Chapter of the American College of Surgeons
- Oregon Patient Safety Commission
- Patient Safety Alliance
- Public Employees Benefit Board
- Regence Blue Cross Blue Shield

APPENDIX B: Organizations Categorized by Major Strategy

Collaborative Quality Improvement Approach

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Oregon Association of Hospitals and Health Systems (OAHHS)
- Oregon Community Health Information Network
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Health Policy Commission
- Oregon IHI 5 Million Lives Network
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance
- The Foundation for Medical Excellence
- Oregon Chapter of the American College of Surgeons
- Oregon Patient Safety Commission
- Regence Blue Cross Blue Shield
- Department of Human Services

Market Based Approaches

- Compare Hospital Costs Web Site
- HB 2213 (2007) – Health Insurance Cost Transparency Bill
- The Health Care Acquired Infection Advisory Committee
- Oregon Health Care Quality Corporation
- Oregon Hospital Quality Indicators
- Oregon Coalition of Health Care Purchasers
- Public Employees Benefit Board
- Oregon Association of Hospitals and Health Systems (OAHHS)

Patient/Consumer Engagement/Education

- Department of Human Services
- Oregon Health Care Quality Corporation

Regulatory Approach (Mandatory Reporting)

- HB 2213 (2007) – Health Insurance Cost Transparency Bill
- The Health Care Acquired Infection Advisory Committee
- Compare Hospital Costs Web Site

OREGON HEALTH FUND BOARD (OHFB)
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORK GROUP
Flip Chart Notes 1/10/08

DRAFT ASSUMPTIONS

- Main Function of QI to coordinate, strengthen and supplement current and ongoing quality improvement and transparency underway in state.

  Discussion:
  - Meaning of state? Fixing everything in Oregon, across Oregon, NOT state government
  - Current? How relate to future? Ongoing should be included
  - Establish goals of QI and transparency as role of QI
  - Strengthen: force for change, advocacy, financial support
  - Owned by state entity
  - Scope – input under reform or bigger around health care quality?
  - Tensions – scope and government
  - Possible role for QI missing for assumption: ongoing role for QI to make recommendations for policy change? What would be the mechanism to inform state policy?
    - Mechanism to inform – state policies – is this role?
  - Should include transparency efforts
  - Create systemness across state
  - Should look at absolutely needed, good to include and what would be included in dream world
  - Part of reform movement but should be part of ongoing improvement
  - Can't reform what can't measure – data measurement and collection; IT systems; info as levers for reform not recommendation for reform

- ~~Unique history/composition~~ Strengthen (or strength of) ~~of~~ stakeholders requires a range of strategies to further quality and transparency agenda – market based, provider collaboration, consumer engagement and regulatory approaches.
  - Is transparency a separate goal?
  - May be other strategies not listed
  - Unique history – what are difference between OR and other states? Diff perspectives? Unique starting point – coming from legislative process
  - Clarification – unique relates to history and organizations (specific govt organizations, stakeholders in play), not the measures that will be used or the work/strategies – QI should build on national work; need to recognize environment and develop QI in context of OR situation
  - Individual efforts, various organizations, might use different strategies
  - QI itself may not use all strategies, but stakeholders will
  - Who owns levers for change?
  - ?? about regulatory authority of QI – not a regulatory agent, but may take recommendations to state agencies with regulatory authority
  - How to collaborate and make parts a whole
  - Recommendation – collaborative nature, capitalize on variety of strategies
  - Respond to charge – develop recommendations for model QI.
  - Narrow roles: central repository, evaluate reform effort and allow measurement; at minimum should measure and report, allowing for better aggregation
    - Statute language includes HIT as basic pieces, necessary for good measurement
  - Wider roles: champion of quality improvement, analysis, goal setting (is duplicative of what already happening?
  - What is role in more effective health care system

- Necessary for ~~(synergestic)~~ collaboration among all stakeholders around common goals will maximize efficient use of resources and eliminate duplicative, as well as help build consensus

among various stakeholders about what effort will be most effective in increasing quality and transparency of care delivered to Oregonians.

- Replace synergistic
- Collaboration → synergy → theory of change
- Goal rather than assumption? Represents goal of what trying to achieve – not easy to get there
- Good faith collaboration necessary
- Need resources to strengthen collaboration, including staff to make collaboration work. Must provide help to achieve own individual goals, as well as group goals. If no intent to give resourced, no added value.
- Assumption: resources are going to be available.
- Development of Common goals: Common goals created through collaboration/alignment of future goals → Where to dedicate $$ (money)
- How does quality fit into redesigned delivery system? Quality should be front and center.
- Define what – best practices
- What vision for the future – what do need to get there?
- Statute doesn't talk about use of data for quality improvement
- Statute as minimum requirements – should also do gap analysis of what state needs

- Collaboration around QI will lead to a high quality system that is safer, more effective, patient-centered, timely, efficient and effective, and better able to contain costs.
  - Definition of quality – should be wrapped into other assumptions

- (Added) Necessary to be backed by adequate resources

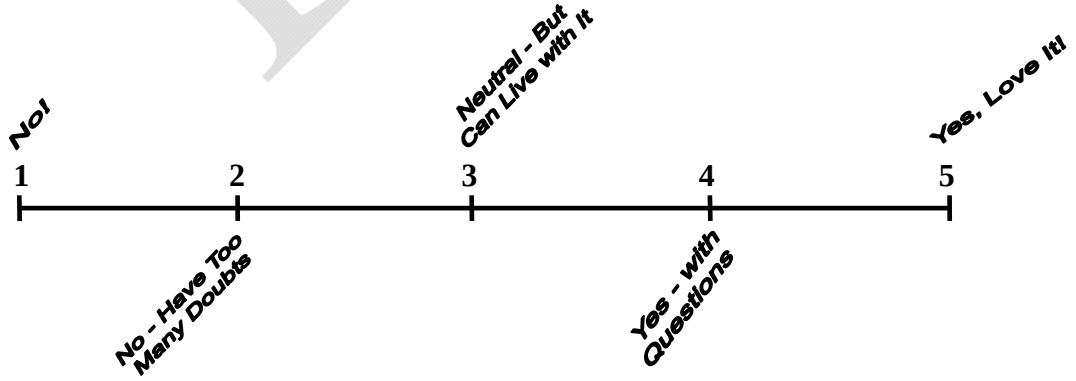
Others

- virtual vs. bricks and mortar?
- Agent of change
- QI drives reform or ongoing effort to improve quality across state? Statute – bigger than just reform
- In order to reform, must have _____ in place.

ROLES FOR QUALITY INSTITUTE

Questions Re: Potential Roles

1. **Is this role clear? Clarify words/phrases?**
2. **What excites you about this potential role?**
3. **The challenge(s) with this role is . . .**
4. **What other organizations/efforts are working this area (besides matrix)**



A. (Nancy Bret, Maureen) Setting ambitious collaborative goals for Oregon in the areas of quality improvement and transparency. Progress towards achieving these goals should be measured and reported and goals should be adapted and updated to encourage continuous improvement.

1. Yes
2. Encourages priority setting about what really matters
    - helps define where the quality groups overlap or don't/AND miss or are uniquely working
    - establishes a necessity to prioritize
3. Difficult to prioritize
    - concern about unfunded mandates, raise expectations and cannot follow through
    - Who decides on what criteria and how does that mesh with others' mandatory priorities?
    - Consumers' point of view bigger than clinical quality
4. National New Group above NQF (!)? Revitalization of primary care – referring out

Vote – 5 (8)
4 (1)

B. (Nancy Bret, Maureen) Overseeing the development of quality measures for a full range of health care services. It should convene public and private stakeholders to develop (or endorse) standard sets of measures to be used across the state. Specific emphasis should be placed on developing a unique set of quality measures for primary care medical homes and behavioral health services

1. Needs to be rewritten – the states role is to align, adopt, apply national metrics
2. Nothing
3. This is wrong
4. NQF and others are creating and developing standard metrics.

Vote for re-write – 5 (7)
4 (1)
2 (1) – this was from Gwen, who wasn't voting on re-write but on given role statement

C. (Nancy, Brett, Maureen) Ensuring data is collected from providers and health plans in a timely manner and disseminated in appropriate formats to various target audiences. Clinic level information about provider performance should be made easily accessible to health care purchasers and other members of the public

1. Role is clear
    - Add: providers mean across continuum – providers, health plans, consumers, etc.
    - Reword: Clarify that we also want providers themselves to have the data to improve
    - Add adjectives accurate and meaningful to data
    - Clarify that data must provide useful/actionable information
    - The right people get the right information (Doctor level, clinic level, etc.)
2. On the road to be able to compare apples to apples and find and promote the best
    - You can lift the worst performers to improve with information ↓↓ unnecessary variation
    - It's what the public wants and needs allow to regain public trust
    - Needs processes standards
3. Currently <u>terribly</u> under-funded
    - Getting hardware and systems, as well as ability to do meaningful analysis and use analysis to drive change - its very hard to do software analysis

- Look at carrots/sticks

Vote – 5 (6)
4 (2)
3 (1)

D. (Jeanene, Gwen) Ensure providers have access to information about cost and quality that allows them compare performance against other providers and create data-driven quality improvement programs. Convene learning collaboratives and provide other technical assistance for providers to develop and share best practices.

1. Role clear? Okay with concept: ensure access to comparable data. Make sure right info to right folks in timely manner
2. What excites? Not just collect, but use to educate, Δ (change) care practices
3. Challenges? "lots" re comparison (comparing apples to applies)
   - need funding for tech assistance
   - ? liability issues/discoverability
4. Who else is working on this?
   - hospital data – hospital assoc. (quality, costs and charges), the state (OHPR hospital quality analysis input)
   - Quality corp – common measures/RWJF aligning forces
   - CareOregon – learning collaboratives for their grantees
   - OHSU – D. Dorr – tech assist to a set of providers (via a grant)

Vote – 5 (6)
4 (3)

E. (Jeanene, Gwen) Develop and test new quality improvement strategies by coordinating and/or funding quality improvement demonstration projects.

1. Role clear? does it fit in one of the buckets?
   - Champion?
   - Projects?
2. What excites? "lots"
3. Challenges?
   - consider for legal issues
   - need for adequate funding – use of research funding
   - need process/staff to develop, coordinate
4. Who else is working on this?
   - Health plans, i.e. Regence + CareOregon
   - Hospital Association + OMA

Vote – 5 (4)
4 (1)
3 (2)
2.5 (1)
2 (1)

F. (Jim, Maribeth) Supporting the development and diffusion of interoperable health information technology to ensure that the right information is available at the right time to patients, providers, and payers.

1. Role clear? Yes. Vague about "support."
2. What excites?
   - Ability to reduce errors
   - Better care

- Save $ (?)
- Time is now: joint ??
- Idea needs independent owner

3. Challenges?
   - Privacy
   - Infrastructure costs
   - Who pays/who benefits
4. Who else is working on this?
   - Q – Corp . . .
   - Gov office HIIAC

Vote – 5 (3)
4 (3)
3 (2)
2 (1)

G. (Jim, Maribeth) Encouraging the development (and/or endorsement) and dissemination of clinical guidelines and evidence-based policies that encourage more effective use of medical technology and clinical procedures, starting with conditions and procedures that are most predominant and costly in the state.

1. Role clear? Yes
   - Encouraging?
2. What excites? A little.
   - eliminate needless variation
   - science based
   - independent clearing house – ICSI
   - opportunity to identify priorities of high resource benefit
3. Challenges?
   - Changing behavior
   - Too many actors
   - Labor intensive?
4. Who else is working on this?
   - What bucket? Different efforts - need for uniformity

Vote – 5 (4)
4 (3)
3 (1)
2 (1)

H. (Gil, Vickie) Encouraging providers to engage patients in shared-decision making by promoting the use of patient decision aids.

1. Role clear? No.
   - Is this Dartmouth inspired?
   - Preference sensitive
   - what kinds of aids?
2. What excites? Maybe.
   - Patient engagement and supporting patient decisions import – right for QI?
   - Dissemination of evidence base/best practice
3. Who else is working on this?
   - Health plans
   - Medical groups
   - Purchasers requiring or encouraging TA groups – TFME, professional associations
4. Challenges?
   - requires redesign

- physician attitudes
- Few resources – intellectual and evidence leader

(Consumer engagement proposed as add on came from this discussion)

Vote – 4 (1)
3 (1)
2 (2)
1 (5)

I. (Gil, Vickie) Seeking opportunities to reward providers who deliver high-value care to their patients by using information about cost, quality and provider performance to drive changes in reimbursement policies.

1. Role clear? Institute's role not clear
   - Think tank/convener
   - Encourage/link best practice - new demos
   - Evaluation
2. Excitement – exciting area to consider how to promote and reward quality
   - Shifts incentives to prevention
3. Challenges?
   - Is this most effective to change? other ways such as:
     - IT infrastructure grants
     - Training
     - Best practice forum
   - Sustainability
   - Shape evidence on what works best
   - $$ for pilots and evaluation
4. Who else is working on this?
   - State/ National experiments
   - Purchasers
   - Health plans
   - Bridges to Excellence
   - California effort

Votes – 5 (3)
4 (3)
3 (1)
1 (2)

J. (Jim, Maribeth) Building on state value-based purchasing efforts and encourage private purchasers to incorporate quality and cost data into purchasing decisions.

1. Role clear? Which efforts? PEBB? Medicaid? Public? Private? Both?
2. What excites?
   - Saving $$/RQI helping
   - Purchasers finding their power
3. Challenges?
   - Atomized
   - Lack of information – What is Quality?
   - Lack of resources to staff the work.

Votes – 4 (3)
3 (3)
2 (3)
One of the 3 votes was for a 5 if applied to plans under SB 329

K. (Mike, Ralph) Develop requirements for health plans that tier providers and/or build provider networks to ensure processes are transparent and quality of care considered along with cost.

1. Role clear? Yes, though "process" = vague, "draft regulations" vs. "requirements"
2. What excites?
   - Might mitigate litigation
   - Promote openness
   - Promote acceptance/validity → activation
3. Challenges?
   - If done poorly → increase litigation. In scope?
4. Who else is working on this?
   - Q Corp
   - Most HP's
   - Local providers
   - Community based/phys. driven

Scope Issue: QI promote openness. QI recommends regulations? Concern about promoting (increasing) litigation of regulations?

Vote – 4 (1)
3 (1)
2 (3)
1 (4)

L. (Mike, Ralph) Advise Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency (e.g. No payment for "never events", requirements on insurers to report claims data)

1. Role clear? yes
2. What excites?
   - Stay on top of best practices and develop OR-specific recommendations
   - Somebody ought to do this!
   - QI think tank here – Central place
3. Challenges? Resources
4. Who else is working on this?
   - Pat safe comm.
   - Health Policy Commission
   - OHPR
   - OHSU – EBM
   - Professional Assns.
   - Health plans.
   - No central place

Take out examples!!

Vote – 5 (8)
4 (1)

<u>Additional</u>

Learning Communities and Technical Assistance: Vote – 5(2), 4(5), 3(2)

Referral/Interface w/ public health issues: Vote – 5(5), 4(2), 3(1)

Patient Education, Engagement – Inform, evidence-based: Vote – 5(5), 4(4)

OREGON HEALTH FUND BOARD (OHFB
DELIVERY SYSTEM COMMITTEE QUALITY INSTITUTE WORK GROUP

December 17, 2007 **Northwest Health Foundation**
2:00 PM **Bamboo Room, Portland, OR**

MEMBERS PRESENT: **Vickie Gates, Chair**
Maribeth Healey, Vice-Chair
Nancy Clarke
Jim Dameron
Gwen Dayton
Gil Muñoz
Ralph Prows, MD
Glenn Rodríguez, MD
Kathy Savicki
Brett C. Sheppard, MD
Maureen Wright, MD
Mike Williams

MEMBERS EXCUSED: **Robert Cohen**
Bob Johnson

STAFF PRESENT: **Tina Edlund, Deputy Administrator, OHPR**
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst

ISSUES HEARD:

- Introductions
- Election of Chair and Vice-Chair
- Review of Workplan
- Review of Delivery System Committee Charter and Oregon Health Fund Board Design Principles and Assumptions
- Environmental Scan of Quality Improvement Initiatives in Oregon
- Vision for Quality in a Reformed Healthcare System
- Public Testimony

Tina Edlund

I. Call to order at approximately 2:10 - There is quorum.

Workgroup members and staff introduced themselves.

II. Nomination and Election of Chair and Vice Chair

The Committee unanimously approved Vickie Gates to serve as Chair and Maribeth Healey to serve as Vice Chair.

Vickie Gates

III. Review of Work Group Workplan

The work group reviewed the draft workplan (Exhibit 3). The group will meet on January 3 and be joined by Dennis Scanlon from Penn State, who will help the group analyze the strengths and weaknesses of other state's quality improvement efforts. On January 10, February 5 and February 27, the group will develop recommendations for the state's role in improving quality of care in Oregon.

Committee members were especially interested in learning about models that have and have not worked in other states and at the federal level (CMS demonstration project). Staff will prepare background material on other state efforts for next meeting.

IV. Review of Delivery System Committee Charter and OHFB Design Assumptions and Principles

Jeanene Smith summarized charge given to Quality Institute Work Group in the Delivery System Charter, as well as the Design Assumptions and Principles of OHFB (Exhibits 4 and 5). Ms. Gates distributed and discussed Oregon Health Policy Commissions related to improving quality (See OHPC Roadmap).

Work group discussed how work of the QI Work Group fits in with work of the Delivery System Committee as a whole.

- Ms. Clarke asked whether recommendations from the work group are limited to roles for the state in facilitating data collection and dissemination.
- Mr. Munoz asked what type of authority the work group will have and whether the main goal should be to lower cost or improve quality. Asked whether could make recommendations that required certain changes or behaviors or whether just setting out best practices. Ms. Gates responded that it is up to the group to determine if they will make recommendations for voluntary or mandatory initiatives.
- Ms. Gates recommended that the group think in two worlds – what would quality look like as part of a larger comprehensive reform and would changes could be made in quality realm even if comprehensive reform failed. Dr. Rodriquez pointed out that other reforms, such as the establishment of an exchange, could open up new opportunities for quality improvement through requirements on accountable health plans. Ms. Gates noted that she wants to make sure that the notion of

accountable health plans does not discourage collaboration across health plans and communities.

Work group members agreed that work group would need to define terms in the charter, including quality and transparency. The work group members agreed that the Institute of Medicine Quality Chasm preamble and definition of quality was a good place to start. There was discussion about various components and possible definitions of transparency. Some work group members don't feel like transparency is a useful term in health care discussions.

V. Environmental Scan of Quality Improvement Efforts in Oregon

- Ms. Clarke updated group on focus and progress of Quality Corporation efforts, focusing on Robert Wood Johnson Foundation funded Aligning Forces for Quality.
- Ms. Dayton told group about efforts of Oregon Association of Hospitals and Health Systems bringing various stakeholders together to define common measures of quality and exploring opportunities to create a data repository of information from various reporting tools.
- Mr. Dameron updated group on progress made by Patient Safety Commission in building adverse event reporting systems, using results to drive safety initiatives and making Oregon the safest state in the nation. Mr. Dameron suggested the work group might want to look at the structure of the Patient Safety Commission, as a "semi-independent state agency" as a model for a quality institute.

Staff distributed matrix which described quality improvement efforts in Oregon (Exhibit 6) and asked for work group feedback on organizations that were missing or information that needed to be updated.

- Dr. Sheppard discussed efforts of Oregon Chapter of American College of Surgeons to engage hospitals in the state in the National Surgical Quality Improvement Program (NSQIP)
- Dr. Prows mentioned HB 2213, which would require health plans to provide their enrollees with information about out of pocket costs for certain procedures. Staff will find out what progress has been made in implementing this bill and will report back to the group.
- Work group members requested a summary of federal government quality improvements efforts that could potentially impact the state.

VI. Vision for Quality in a Reformed Healthcare System

A number of work group members stated again that they think the IOM Quality Chasm preamble and definition of quality are a good place to start in developing a vision for quality. Ms. Clarke noted that the Quality Corporation has translated these principles into simpler language.

- Dr. Wright suggested that the group might want to set specific goals for the state, i.e. leader in prevention.
- Ms. Sivicki talked about how mental and behavioral health largely left out of the quality discussion, but account for a large part of healthcare spending. She would like to ensure that a system for measuring quality of mental and behavioral health services is created.
- Ms. Healy discussed role of quality in supporting the patient-provider relationship and as an important part of trust.
- Ms. Clarke suggested that the work group should consider multiple ways to stage quality improvement efforts. Different tools and information will be useful for different groups – consumers, purchasers, peer groups, individual providers.
- Ms. Dayton wants to make sure group focuses on how state can move towards higher quality. There is a lot of good work going on and need to find a way to coordinate into a common effort.
- Dr. Rodriquez thinks that quality problems arise because don't have a "system" so it is difficult to provide feedback.

Staff will work with chair and vice-chair before the next meeting to draft a Vision for Quality, starting with the IOM preamble and definition of quality and incorporating member comments.

V. Public Testimony Public Testimony

No guests present wished to provide testimony. At future Committee meetings, 20 – 30 minutes will be set aside for public testimony.

Meeting adjourned at approximately 4:45 p.m.

Submitted by:
Ilana Weinbaum
Policy Analyst

Reviewed by:
Tina Edlund
Deputy Administrator

EXHIBIT SUMMARY

1 – Agenda
2 – Work Group Roster
3 – Draft Work Group Workplan
4 – Delivery System Committee Charter
5 – OHFB Design Principles & Assumptions

Building The Capacity to Improve Health Care Quality & Value: Examples & Lessons From Across the Country

Dennis P. Scanlon, Ph.D.
Associate Professor of Health Policy & Administration
The Pennsylvania State University

January 3, 2008
Portland, OR

Outline

- My Background
- Defining the goals and scope of the QI workgroup
  - What problems need fixed?
  - A framework for approaching the workgroup's charge
- 'Theory of Change'
  - Various models of behavior change and their assumptions and evidence base
- Examples of QI initiatives from around the country
- Key takeaways and implications for Quality Institute Workgroup
- Questions and Discussion

My Background

- Health Economist & Health Services Researcher
- Faculty Member at Penn State for 11 Years
- Health Systems Improvement Research
  - Role of information, incentives, and behavior change in improving health systems outcomes
- Examples of projects
  - Employers (GM, Boeing, NBCH)
  - Health Plans (BSCA, Highmark)
  - Quality Measurement (HEDIS, CAHPS, HCUP)
  - Accrediting Bodies (NCQA, JCAHO)
  - State Medicaid Programs (SC, AK, NC, RI)
  - Provider Organizations (CareSouth, Monroe)
  - Regional Initiatives
    - Aligning Forces for Quality (RWJF)
    - Regional Quality Initiative (CHCS)

What Needs Fixed?

- Institute of Medicine Error Report (1999)
  - 44,000 to 98,000 deaths per year due to preventable inpatient medical errors
- Institute of Medicine Quality Report (2001)
  - Serious quality problems exist in all sectors of health care (inpatient, outpatient, acute, chronic, etc.)
  - Overuse, Underuse, Misuse
  - Fundamental system changes are needed
- McGlynn et al. (2003)
  - On average, American's receive recommended care and treatment 50% of the time
- Zhan & Miller (2003)
  - Significant variation in the impact of inpatient medical injuries on mortality, length of stay, and charges

What Needs Fixed?

- AHRQ's National Healthcare Disparities Report (2005)
  - Significant "inequality in quality" in U.S.
  - Differences by race, ethnicity & socioeconomic status
- Increasing trends in chronic illness, obesity & overweight, childhood obesity and poor health behaviors
- Poor Value for Health Care Expenditures
  - MBGH/Juran Institute Report (2002) estimated the cost of poor quality of care ~ $1,800 per employee/year
  - Some experts estimate that as much as 30% of health care expenditures are due to waste/inefficiency

Defining the Goals and Scope: Choosing Where to Focus

- IOM's Six Domains for Quality Improvement
  - Safety
  - Effectiveness
  - Patient Centeredness
  - Timely
  - Efficient
  - Equitable
- Care Type
  - Acute care
  - Ambulatory care
  - Prevention
  - Long term care
  - End of life care

Defining the Goals and Scope: Choosing Where to Focus

- Care Providers
  - Hospitals
  - Health systems
  - Physicians (individuals, groups)
  - Nurses
  - Other non-physician clinical practitioners
- Care Providers
  - Health plans
  - Nursing homes
  - Home health
  - Pharmacy
  - Community and social service agencies

Defining the Goals and Scope: Choosing Where to Focus

- Quality Improvement Organizations
  - Purchaser groups
  - Provider groups
  - Health plan groups
  - State governments
  - Federal government
  - Multi-stakeholder coalitions
- Quality Improvement Strategies
  - Market based approaches
  - Collaborative QI approaches
  - Patient/Consumer education/engagement
  - Regulatory approaches
  - Mixed model approaches

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Market Based Approaches
   - Demand side driven
     - Value based purchasing
     - Consumer choice
   - Market share penalties
   - Role of incentives and need for payment reform (e.g., P4P)
   - Information & transparency to improve market functioning

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Collaborative Quality Improvement Approaches
   - Supply side driven
   - Best practice sharing
   - Continuing education & training
   - Individual & organizational self interest vs. common good
   - Continuous quality improvement and practice re-design
   - Funding for QI investments

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Patient/Consumer Engagement
   - Both supply & demand side driven
   - Responsibility of patients for prevention, self management and responsibility
   - Education about patient role and resources to support patient activation and decision making
   - Expanded role for public health agencies, employers, and community/consumer agencies/advocates

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Regulatory Approaches
   - Accreditation
   - Licensure
   - Continuing education requirements
   - Audit and review
   - Public accountability & transparency

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Mixed Model Approaches
   - Combines elements of:
     - Market based approaches
     - Collaborative QI approaches
     - Patient/Consumer engagement
     - Regulatory approaches
   - Multi-stakeholder community based initiatives
     - “Stakeholder Alignment”

A Framework for the QI Workgroup

- Specify the following, including relevant weights:
  - QI domain(s)
  - Care type(s)
  - Providers
  - QI strategies
  - QI organizations
- Consider examples and options
  - What are local strengths?
  - What have others done?
  - Evidence base and assumptions for options
- Develop a logic model or “theory of change”
- Assess costs and feasibility
- Be realistic about time horizon

Importance of Being Transparent About Assumptions & Evidence

- There is more anecdotal evidence than scientific evidence for many proposed reform programs
- Existing scientific evidence is often based on activities of non-representative stakeholders
- Costs and benefits often depend on important details such as time horizons, provider capacity, reimbursement mix, etc.
- 3 Examples
  - Pay for Performance
  - Tiered consumer incentives
  - Supply chain market ‘approaches’

CALIFORNIA HEALTH PLANS PAY OVER $55 MILLION TO PHYSICIAN GROUPS FOR REACHING IHA PAY FOR PERFORMANCE MEASURES

IHA NEWS RELEASE
OAKLAND, Calif., February 14, 2007 – Traditional approaches to physician compensation don't reward appropriate care, but California's pioneering **P4P program realigns incentives**. It **supports the need of physicians** to have uniform performance measures against which to gauge important indicators of quality, while also **providing consumers with valuable information** to guide their choices," said Donald J. Rebhun, MD, chairman elect of IHA's board of directors.
Motivated by the P4P program, physician groups in 2005 reported screening about **60,000 more women for cervical cancer**, testing nearly **12,000 more diabetics**, and administering approximately **30,000 more childhood immunizations** than during the previous year for their patients enrolled in participating health plans.

The New York Times

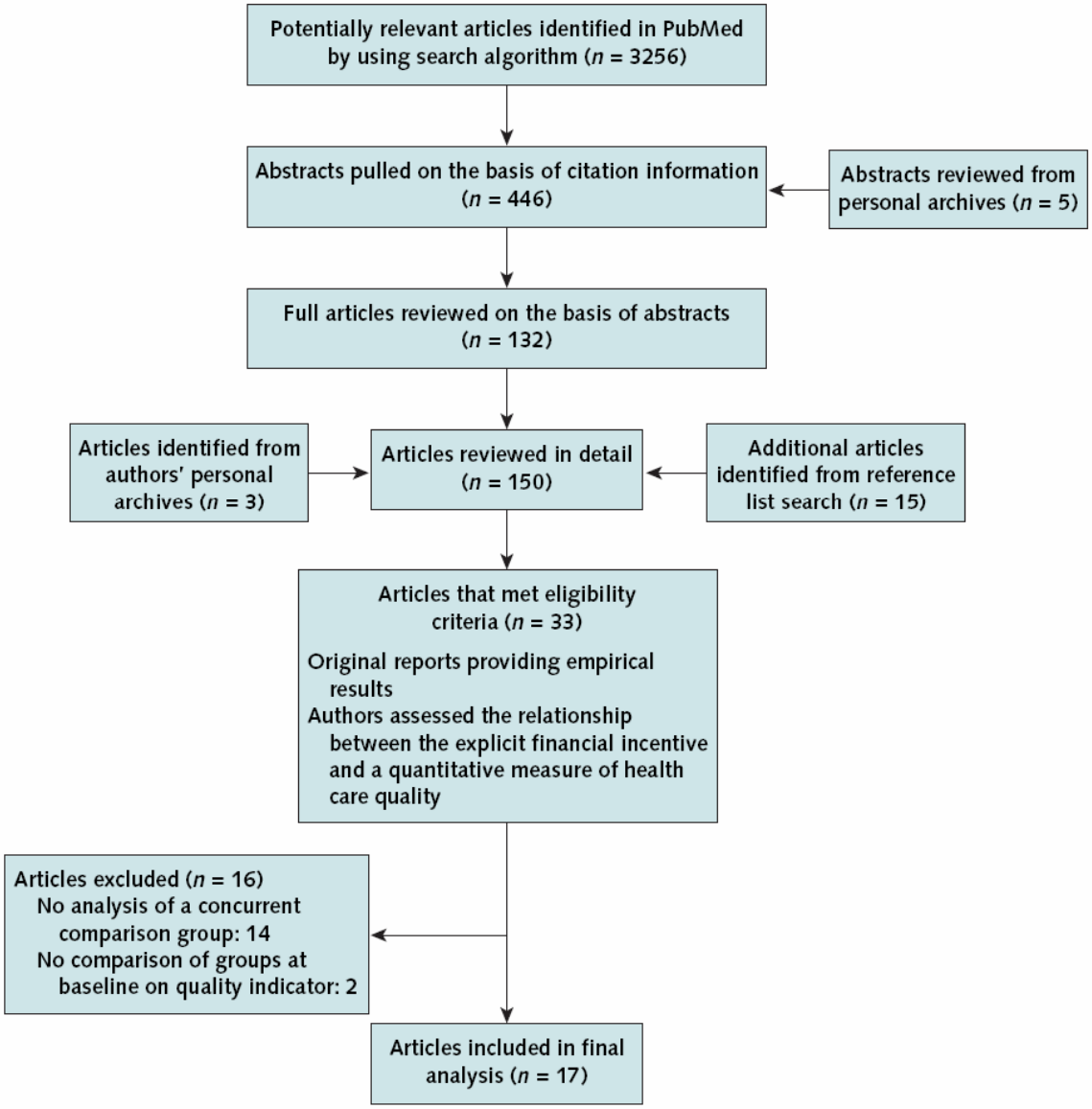
Bonus Pay by Medicare Lifts Quality

By REED ABELSON
Published: January 25, 2007

The 266 hospitals participating in a Medicare experiment that pays them more to follow medical recommendations have steadily **improved the quality** of patient care.

Medicare officials also emphasize that the vast **majority of hospitals were able to deliver better care**. “We continue to see improvement, quarter by quarter, in this cohort of hospitals,” said Herb Kuhn, the acting deputy administrator for Medicare.
The hospitals experienced nearly **1,300 fewer deaths** in treating heart attack patients, and they have generally been able to **score higher on quality measures** than the rest of the nation’s hospitals.

Figure. Studies published between 1 January 1980 and 14 November 2005 and evaluated for inclusion in the systematic review of explicit financial incentives for health care quality.



Regence BlueShield

Hospital Safety Incentive

The Traditional Medical Plan has a network hospital benefit of 95% for **certain union groups**. However, if you choose a network hospital that meets certain patient safety standards, your benefit is 100%. This is the hospital safety incentive. *In order to be eligible for the hospital safety incentive, your hospital must meet the patient safety standards defined below on the date you are admitted to the hospital.*

Patient Safety Standards

These patient safety standards were developed by The Leapfrog Group, a nonprofit organization focused on preventing medical mistakes. The three standards are aimed at reducing medical errors, improving the quality of patient care and ultimately saving lives. They are:

Computerized Physician Order Entry (CPOE) - Electronic prescribing systems are in place to coordinate physician orders with patient information and automatically check for errors or problems.

Intensive Care Unit Physician Staffing (IPS) - Intensive care units are staffed with specialists who focus on the care of critically ill and injured patients.

Evidence-based Hospital Referral (EHR) - Hospitals with extensive experience with certain procedures have been shown to have better outcomes for patients.

How the Incentive Works

The hospital safety incentive is based on a patient's primary diagnosis and applies to inpatient and outpatient services (including emergency room services) that are billed by the hospital. Most charges not billed by the hospital will be paid at 95%. For example, if the hospital contracts for laboratory services, and the laboratory bills for services received at the hospital, then services are not part of the hospital safety incentive and will be paid at 95%.

Find A Hospital

If you are having one of the procedures listed below, the hospital must meet the EHR standard for you to receive the 100% hospital safety incentive. Your physician can assist you in determining if your procedure is an EHR procedure. Select your procedure from the list below to find out which hospitals qualify for the hospital safety incentive:

Current Benefit Year
July 1, 2004 thru June 30, 2005

- Abdominal Aortic Aneurysm
- Coronary Artery Bypass Graft
- Esophagectomy
- High-risk Delivery
  - Expected birth weight less than 1500 grams,
  - Gestational age less than 32 weeks or
  - Prenatal diagnosis of major congenital anomaly
- Pancreatic Resection
- Percutaneous Coronary Intervention

New Benefit Year
Beginning July 1, 2005

- Abdominal Aortic Aneurysm
- Coronary Artery Bypass Graft
- Esophagectomy
- High-risk Delivery
  - Expected birth weight less than 1500 grams,
  - Gestational age less than 32 weeks or
  - Prenatal diagnosis of major congenital anomaly
- Pancreatic Resection
- Percutaneous Coronary Intervention

All other medically necessary inpatient and outpatient services must be billed by a hospital that meets both the CPOE and IPS standards in order for the 100% hospital safety incentive to apply. Select the link below to find hospitals that qualify for the 100% hospital safety incentive.

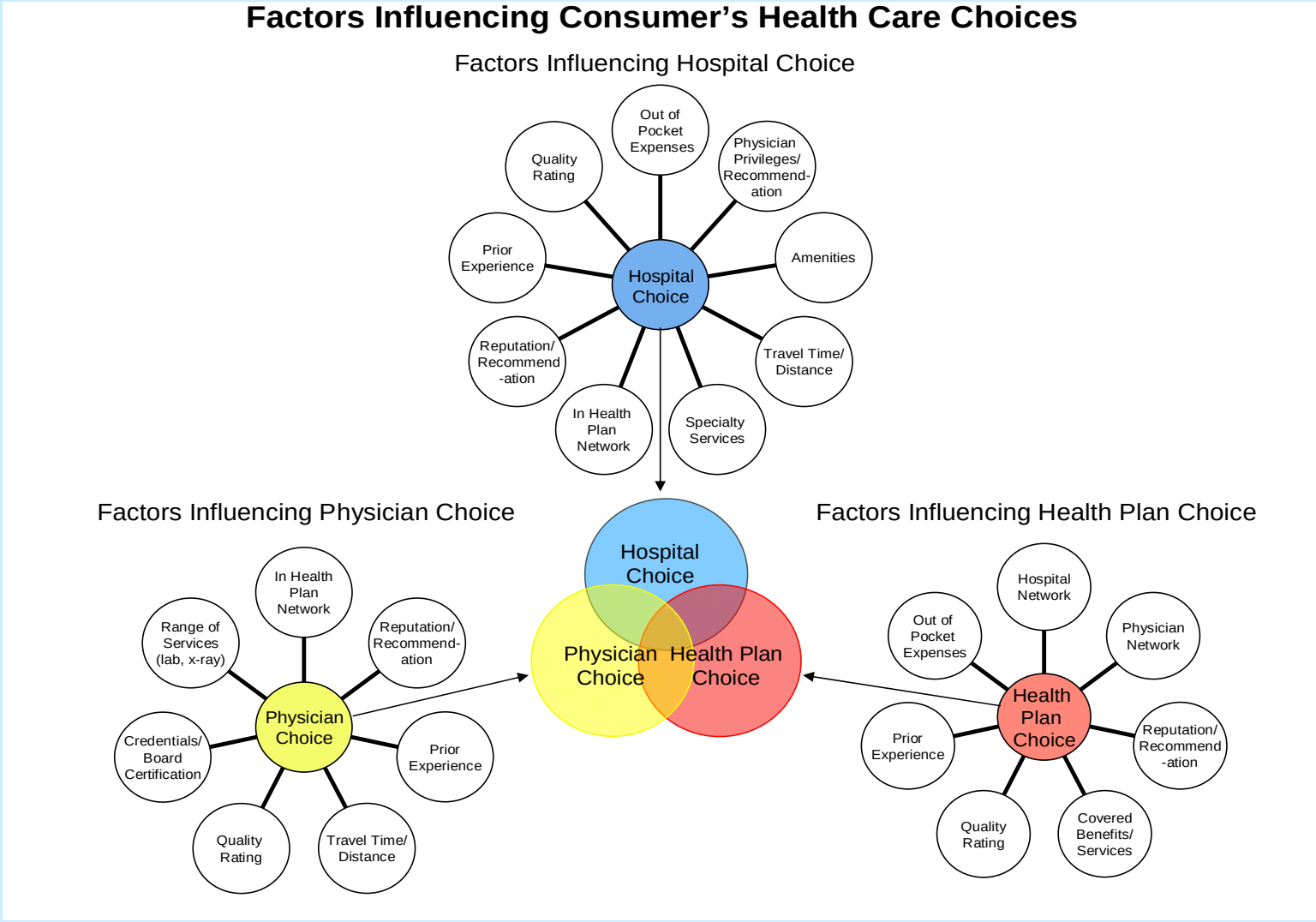
Current Benefit Year
July 1, 2004 thru June 30, 2005

- CPOE and IPS Hospitals

New Benefit Year
Beginning July 1, 2005

- CPOE and IPS Hospitals

Conceptual Framework for Studying Tiered Hospital Benefit Programs

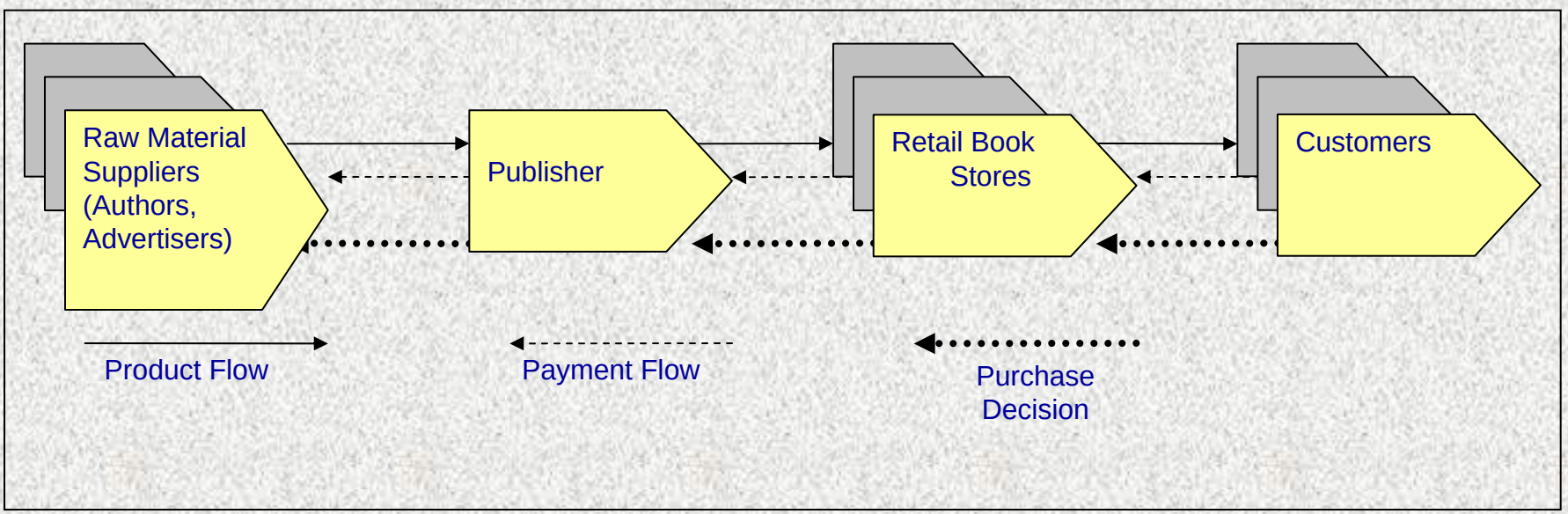


Boeing Study Key Takeaways

- If physician-patient relationships dominate and physician hospital privileges are limited, then a financial incentive geared towards consumers may have little impact
  - More effective alternative approaches may include hospital or physician incentives
- What dollar amount would it take to get patients to consider doctor and hospital switching?
  - Study was not designed to answer this question
- What is the optimal timing of incentive program implementation when few providers meet the preferred tier initially?
  - From the plan, employer, and payer perspectives
  - Choices must be convenient for patients and include a significant number of physicians as in the CABG example

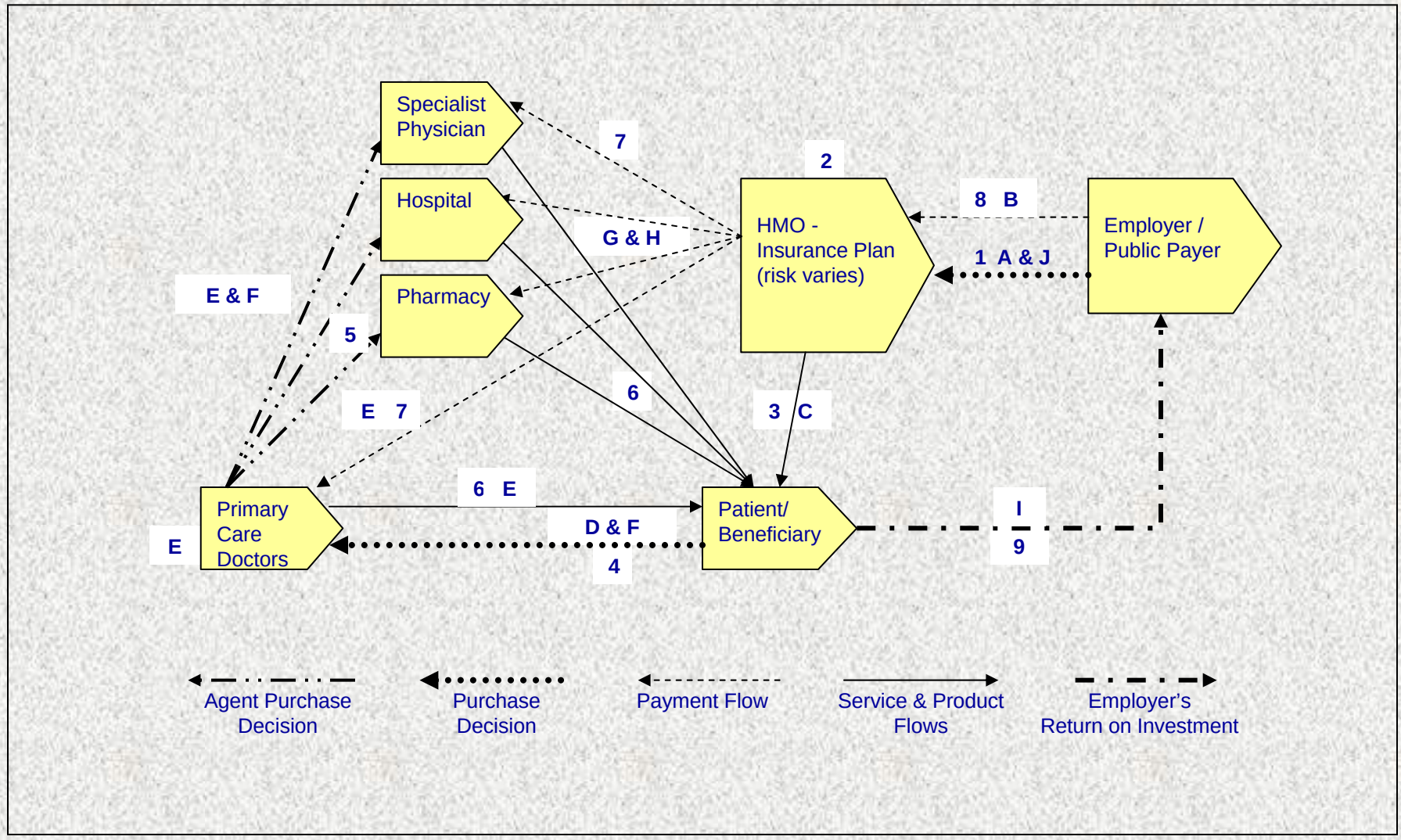
Market Based Efforts to "Align Incentives"

Example of a Simple Supply Chain Adapted from Porter



Source: Michael E. Porter. *Competitive Advantage: Creating and Sustaining Superior Performance. Copyright 1985, 1999. Adapted with permission of the Free Press, a division of Simon and Schuster.*

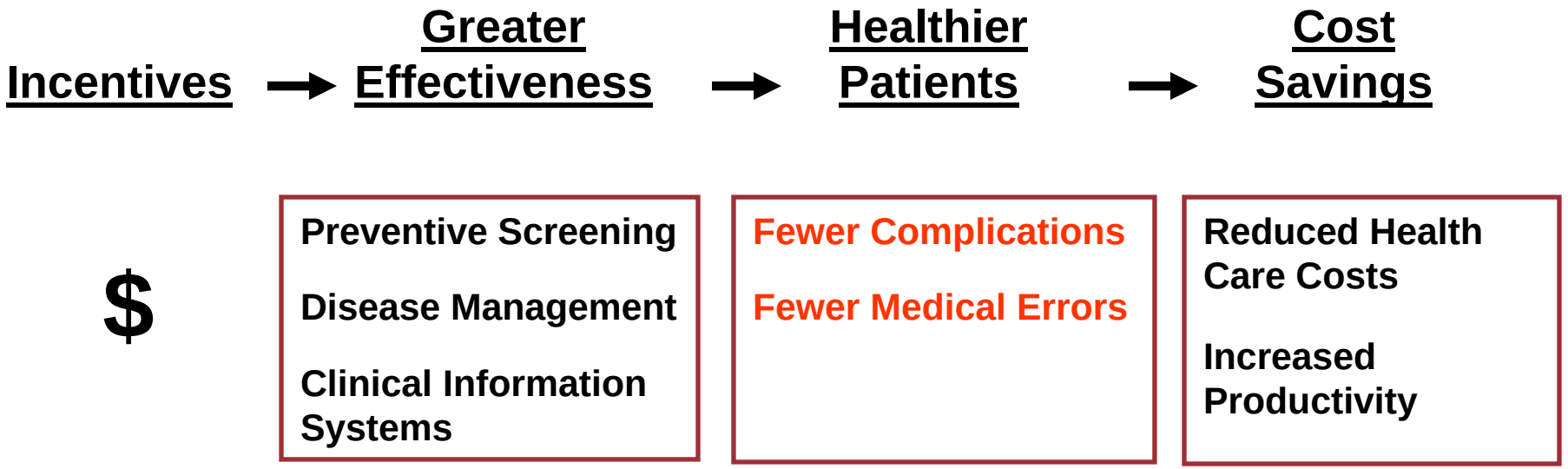
A Simplified Health System Supply Chain from a Payer's Perspective



Health Care Excellence → Cost Savings

- **Empirical studies and actuarial research**
- **Adherence to evidence-based clinical guidelines results in:**
  - Improved patient health
  - Improved productivity and reduced absenteeism
  - Reduced overall health care costs
  - E.g., Diabetes care excellence → $300-$400 per pt cost savings
- **Concept behind Bridges to Excellence**
  - Give ½ of projected cost savings per patient to physicians as reward for health care excellence
  - Reward to these top physicians will incentivize other physicians to change practice patterns

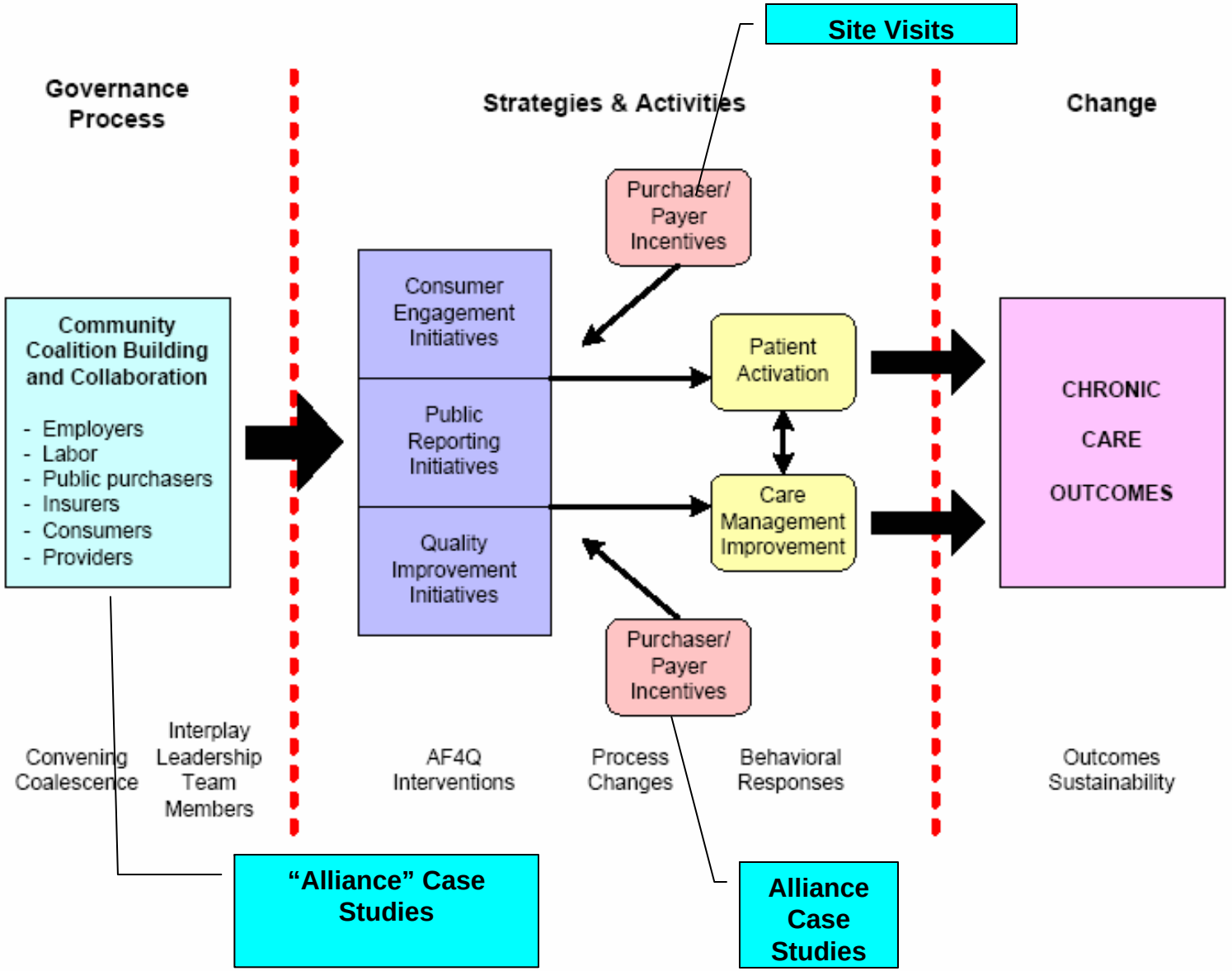
Employer (Payor) Perspective: Improved Effectiveness Leads to Cost Savings



“Theory of Change” and Logic Model Development

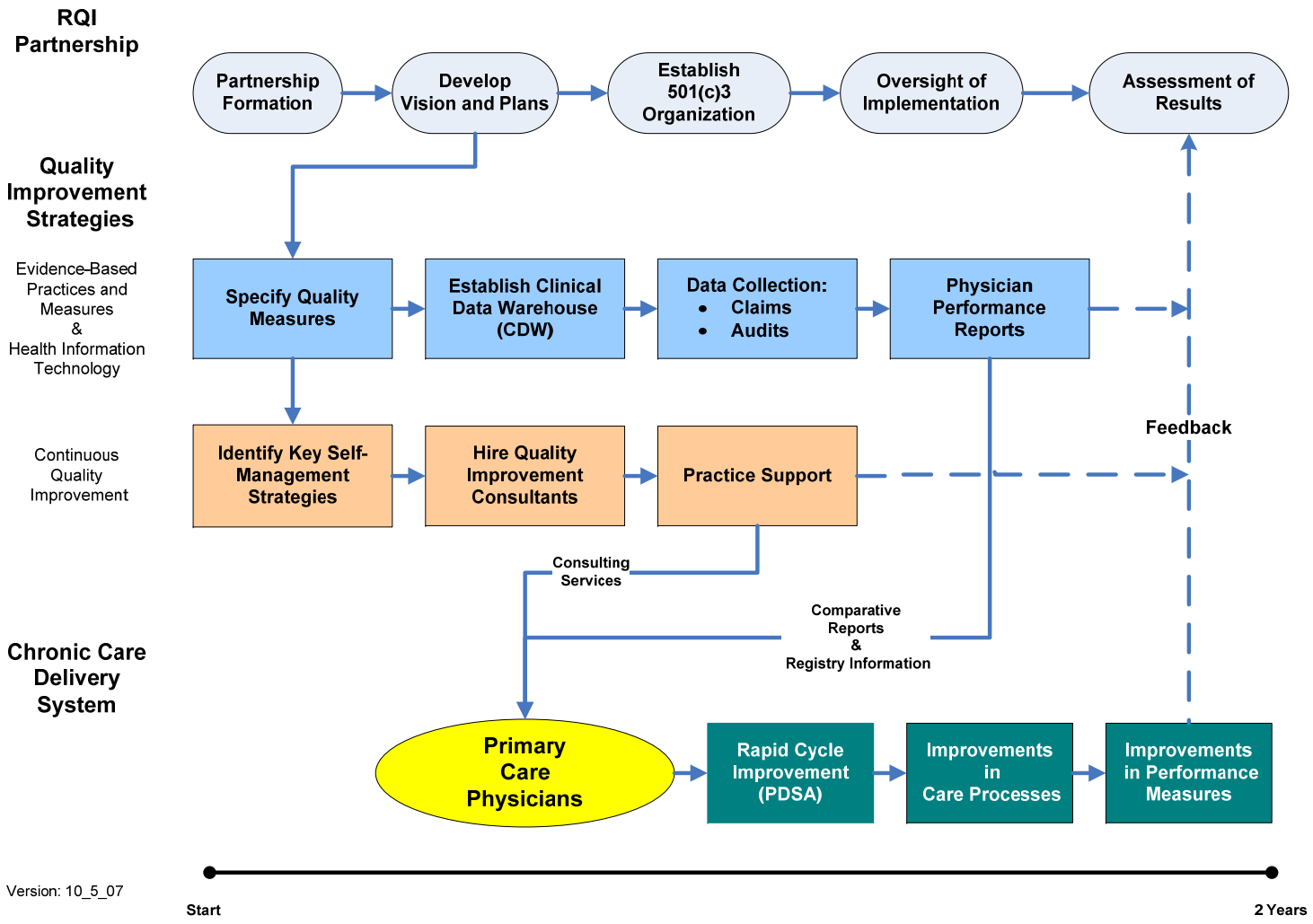
- A graphic depiction of the sequence of interventions and the expected effect of those activities
- Helpful in clarifying expectations regarding ‘cause and effect’ and in being more explicit about assumptions and uncertainty
- Useful for explaining the ‘logic’ of recommendations to stakeholders
- Examples
  - AF4Q
  - North Carolina Regional Quality Improvement Project

AF4Q Evaluation: Logic Model



North Carolina RQI Logic Model

Evaluation level



Version: 10_5_07

Examples of QI Efforts from Other States and Communities

- Examples may be useful for the Delivery System Committee and the Quality Institute Work Group
- Note the diversity of approaches, including variation in domains, care types, providers, QI strategies and QI organizations
- Local market and historical context are very important!
  - Physician practice organization in Twin Cities, MN

Pacific Business Group on Health- At a Glance

- Typology: Purchaser group
- Primary strategy: The “market”
- Focus:
  - Domain: Safety, provision of evidence based care, cost
  - Care type: Acute care, ambulatory care
  - Unit: Hospitals, physicians, health plans

Pacific Business Group on Health-History

- The Pacific Business Group on Health (PBGH) formed in 1989
- Business coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost
- Members spend nearly $10 billion annually to provide health care coverage to more than 3 million employees, retirees and dependents
- PBGH is a 501(c)3 corporation

Pacific Business Group on Health Activities

- **Transparency**
  - **Medical Groups and Physicians-** Promote advancements in provider performance reporting through work with the Integrated Healthcare Associations Pay-For-Performance project and through Physician Measurement efforts. The latter includes designation as one of six national pilots to work with Centers for Medicare & Medicaid Services (CMS) and the AQA Alliance to pilot the collection and reporting of physician-level performance information.
  - **Hospitals-** The Leapfrog Patient Safety Initiative is focused on encouraging consumer decision-making at the hospital level. Health plans have played an important role in encouraging hospitals to participate in this effort, and doctors will have a key role in advising their patient's on hospital choice.
  - **Health Plans/Medical Groups-** The California Healthcare Quality Report Card provides standardized, comparative information on health plans. Since 2001, PBGH has served as a vendor, providing technical expertise and helping the Office of the Patient Advocate build on existing tested measures rather than start from scratch.

Pacific Business Group on Health Activities

- Quality Measurement and Improvement
  - **Disease Management Effectiveness Program-** Evaluates existing disease management programs against criteria endorsed by national experts.
  - **The Silicon Valley e-Health Pilots-** Seek to enhance patient-doctor communication and tested new ways to reimburse physicians for e-visits.
  - **CALINX, the California Information Exchange-** Effort by California purchasers, plans and providers to collaborate in the development of standards for the exchange of health care information.

Pacific Business Group on Health Activities

- Policy Development & Advocacy – Areas of Focus
  - Care quality measurement
  - Provide consumer with useful quality and price information
  - Reward providers for doing a better job
  - Adopt health information technology
  - Re-engineer how care is delivered
  - Reduce disparities in quality of care
  - Building healthcare value

Institute for Clinical Systems Improvement (ICSI)- At a glance

- Typology: Provider group (with health plan funding)
- Primary strategies: Clinical quality improvement
- Focus:
  - Domain : Provision of evidence based care
  - Care type: Ambulatory care
  - Unit of focus: Providers

Institute for Clinical Systems Improvement-History

- An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans in Minnesota
- Founded in 1993 by HealthPartners Medical Group, Mayo Clinic and Park Nicollet Health Services
- Has 62 members and is funded by all six Minnesota health plans. The combined medical groups and hospital systems represent more than 7,600 physicians

Institute for Clinical Systems Improvement-Activities

- Scientific Groundwork for Health Care
  - Clinicians from member organizations survey scientific literature and draft health care recommendations based on the best available evidence
  - Subjected to an intensive review process that involves physicians and other health care professionals from ICSI member organizations before they are made available for general use
  - Examples
    - Care Guidelines
    - Order sets and protocols
    - Technology Assessments

Institute for Clinical Systems Improvement-Activities

- Support for Improvement
  - Events, tools and offerings of support to ICSI member organizations used to aid members in quality improvement structure, knowledge, and progress towards achieving their aims
  - Examples
    - Patient Education Resources
      - Disease-specific education materials developed by ICSI member groups that may be downloaded and distributed
    - Summary Reports
      - Documentation of strategies and lessons learned within participating member organizations in the improvement of a process of care, clinical outcome, satisfaction of care, or waste reduction

Institute for Clinical Systems Improvement-Activities

- Summary Reports Examples
  - Chest Pain (Acute) Initiative at Park Nicollet Health Services
  - Colon Cancer Screening Rate Improvement at CentraCare
  - Advanced Access in a Multi-Specialty Group (RiverWay Clinics)
  - Advanced Access Changes to Improve Mammography Waiting Time & Rates at North Clinic
  - Access to Care Improvement at Four Medical Groups

Pittsburgh Regional Health Initiative (PRHI)- At a glance

- Typology: Multistakeholder group
- Primary strategies: Mixed: Market and clinical quality improvement
- Focus:
  - Domain: Safety, provision of evidence-based-care
  - Care type: Ambulatory care, Acute care
  - Unit: Physicians, hospitals, nurses

Pittsburgh Regional Health Initiative – History and Structure

- Regional consortium of medical, business, and civic leaders to address healthcare safety and quality improvement as a social and business imperative
- Includes the institutions and individuals that provide, purchase, insure and support healthcare services in the Pittsburgh region
- Nonprofit operating arm of the Jewish Healthcare Foundation with funding from local corporations, foundations, health plans and government contracts and grants

Pittsburgh Regional Health Initiative - Activities

- Perfecting Patient Care (PPC)
  - Using the Toyota Production System as a model, PRHI developed a quality improvement method for clinical settings
  - Aims to eliminate errors, inefficiency and waste in complex systems through continuous improvement and standardization of work practices
    - Supported much of the ground work for PA's Hospital Acquired Infection reporting system, including ROI analysis
  - Practices are taught at an 'open university' or as on-site customized training

Pittsburgh Regional Health Initiative - Activities

- Chronic Care Improvement
  - PRHI has been dedicated to improving the delivery of chronic care since 2000, when it commissioned region-specific data on diabetes indicators for Southwestern Pennsylvania
  - Two working groups, representing multiple stakeholders, formed around Diabetes and Depression to study the data and take action
  - As they explored how to improve the delivery of care to people with those two conditions, they quickly discovered that the barriers to be removed were common to both disease states.
  - By 2003 the two groups had combined into one: the Chronic Care Model Action Group
  - Efforts in 2007 turned to one of the most enduring barriers: the current payment system for healthcare delivery

Pennsylvania Health Care Cost Containment Council (PHC4)- At a glance

- Typology: State government
- Primary strategies: The “market”
- Focus:
  - Domain: Provision of evidence-based-care, safety, cost, equity
  - Care type: Ambulatory, acute care, efficiency
  - Unit of focus: Providers, hospitals, health plans

Pennsylvania Health Care Cost Containment Council - History

- Independent state agency, formed under Pennsylvania statute (Act 89, as amended by Act 14)
- Responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay
- Funded through the Pennsylvania state budget and receives revenue through the sale of its data to health care stakeholders

Pennsylvania Health Care Cost Containment Council - History

- Strategy to contain costs is to stimulate competition in the health care market by:
  - Providing comparative information about the most efficient and effective health care providers to individual consumers and group purchasers of health services
  - Providing information to health care providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver

Pennsylvania Health Care Cost Containment Council - Activities

- Responsibilities
  - Collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania
  - Study, upon request, the issue of access to care for those Pennsylvanians who are uninsured
  - Review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth

Pennsylvania Health Care Cost Containment Council - Activities

- Data Collection
  - Collects over 3.8 million inpatient hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers in Pennsylvania
  - Data is collected on a quarterly basis
  - Collects data from managed care plans on a voluntary basis

Pennsylvania Health Care Cost Containment Council - Activities

- Examples of Reports
  - Hospital Performance Report 2006
  - Choosing a Medicare Advantage Plan for 2008
  - Hospital Financial Analysis 2006
  - Cardiac Surgery in Pennsylvania 2005
  - PHC4 Research Brief - Clostridium difficile Infections in Pennsylvania Hospitals

PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL

Cardiac Surgery in Pennsylvania 2005

The Interactive Database can be searched by either hospital or surgeon.

Once selected, the hospital and surgeon specific pages will display the number of cases, statistical ratings for in-hospital mortality, 30-day mortality, 7-day and 30-day readmissions, and post-surgical length of stay. When a hospital is selected the average charge, average commercial payment and average Medicare payment are also displayed.

Please make your selection from the list boxes below.

Hospital

Statewide
Abington Memorial
Albert Einstein
Allegheny General

Go!

Surgeon

Michael A. Acker
V. Paul Addonizio
Dahlia M. Alspaugh
John S. Anastasi

Go!

Hold down **"Ctrl"** Key to select multiple Hospitals or Surgeons

View Other Years

(•) 2005 ( ) 2004 ( ) 2003 ( ) 2002 ( ) 2000

PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL

Cardiac Surgery in Pennsylvania 2005

Symbol Legend

- ● Significantly higher than the expected rate.
- ◉ Not significantly different than the expected rate.
- ○ Significantly lower than the expected rate.
- NR Not Reported (too few cases).

Conemaugh Valley Memorial

Hospital	# of Cases	Mortality Rate In - Hospital	Mortality Rate 30 - Day	Readmission Rate 7 - Day	Readmission Rate 30 - Day	Length of Stay	Average Charges	Average Payments Commercial	Average Payments Medicare
Conemaugh Valley Memorial									
CABG without Valve	309	○	◉	◉	◉	4.8	$62,053	$23,476	$28,233
Valve without CABG	50	◉	◉	◉	◉	5.4	$89,906	$40,429	$36,666
Valve with CABG	64	◉	◉	◉	◉	6.8	$106,836	$35,368	$38,863
Total Valve	114	◉	◉	◉	◉	6.1	$97,952	$38,482	$37,914

Choose Another Hospital / Surgeon

Quality Improvement Organizations (QIOs)- At a glance

- Typology: Federal government
- Primary strategies: Clinical quality improvement
- Focus:
  - Domain: Provision of evidence-based-care, safety, cost, access
  - Care type: Ambulatory care, acute care
  - Unit of focus: Providers, hospitals, health plans

Quality Improvement Organizations

- QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly patients from underserved populations
- The Program also safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care

Quality Improvement Organizations Activities

- The 9th Round SOW work themes:
  - Beneficiaries protection (case review)
  - Prevention
  - Patient safety
  - Care coordination/patient pathways
  - The six IOM QI domains
- Cross-cutting themes:
  - Promoting the use of health information technology and electronic health records
  - Reducing health care disparities
  - Emphasizing value in health care

Important National Trends

- There are lots of important activities and changes happening nationally by public and private entities that are important to understand as you develop the plan for Oregon's Quality Improvement Institute
- Examples
  - NQF and QASC
  - DHHS' "Value Exchanges"
  - CMS' P4P
  - Advanced Medical Home
  - RWJF's 'Aligning Forces for Quality' and 'Regional Market Strategy'
  - CHCS' Regional Quality Initiative

Measure Development : National Quality Forum (NQF)

- Private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting.
- Primary function is to “endorse” national quality measure

National Quality Forum- Activities

- Examples of endorsed measures:
  - Acute care
    - Cross cutting measures
    - Clinician level measures
    - Condition specific measures
    - Patient experience
    - Safety
  - Ambulatory care
    - Condition specific measures
    - Patient experience
    - Prevention measures

Note: See http://www.qualityforum.org/pdf/lsEndorsedStandardsALL08-14-07corrected.pdf for full list of acute care and ambulatory care measures

National Quality Forum- Other Priority Areas

- Also developing measures and standards for (examples):
  - Cancer care
  - Health IT structural measures
  - Emergency care
  - Home health care patient experience
  - Immunization quality
  - Therapeutic drug management
  - Laboratory medicine communication
  - Nursing-sensitive care

DHHS: Value Driven Health Care Initiative

- Established in response to August, 2006 executive order calling for increased quality, efficiency within healthcare system
- Four cornerstones:
  - Interoperable Health Information Technology (Health IT Standards)
  - Measure and Publish Quality Information (Quality Standards)
  - Measure and Publish Price Information (Price Standards)
  - Promote Quality and Efficiency of Care (Incentives)

Source: Department of Health and Human Service: Value Driven Health Care Home, available at: http://www.hhs.gov/valuedriven, accessed July 31, 2007.

“Value Exchanges”

- Multistakeholder organizations that bring together purchasers, providers, health plans, consumers to advance four cornerstones of Value Driven Health Care Initiative in local communities
- Align varied strategies, interests of multiple community players
- “Formally” recognized by DHHS via application process
- Can participate in “Learning Network” through Agency for Healthcare Research and Quality (AHRQ) to support their work

Source: Department of Health and Human Service: Value Driven Health Care Home, available at: http://www.hhs.gov/valuedriven/, Accessed July 31, 2007.

CMS Hospital Value-Based Purchasing

- Proposal announced April, 2007
- Starting in October 1, 2008, proposed to replace present pay-for-reporting structure
- All hospitals eligible to receive a specified percent of payment based on performance
- Incentive system based on performance and improvement

DHHS, "Hospital Value Based Purchasing," available at:http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf, accessed July 31, 2007.

CMS Physician Quality Reporting Initiative (PQRI)

- Medicare physician pay for reporting program
- Starting July 1, 2007 physicians can earn 1.5% bonus for reporting quality
- CMS pay-for-reporting programs tend to be precursor to pay-for-performance programs

Source: Centers for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/PQRI/, accessed July 31, 2007.

CMS Premier Demonstration

- Initiated in March 2003
- 260 hospitals report on 33 measures
- Payments/Penalties
  - Hospitals performing in top two deciles receive 1–2%
  - Underperformers penalized 1–2% of Medicare payment
  - Payments average $72,000 per hospital
- Demonstration has been extended for three more years

Source: Premier, Inc., available at: http://www.premierinc.com, accessed July 31, 2007.

RWJ Aligning Forces for Quality (AF4Q)

- Grants provided to communities to align key forces, including health care providers, health care purchasers, and health care consumers
- Alliances work on three activities:
  - Quality improvement
  - Quality reporting
  - Consumer engagement
- Expanding focus to include inpatient care, nursing, and disparities in 2008
- Quality Corporation in Oregon is one of 14 selected communities

Advanced Medical Home

- American College of Physicians (2006) calls for voluntary certification and recognition of primary care and specialty medical practices as “advanced medical home”
- “Advanced medical home acknowledges that the best quality of care is provided not in episodic, illness-oriented, complaint-based care -- but through patient-centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine.”

Source: American College of Physicians, **The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care, 2006.**

Key Attributes

- Care Model: Organize the delivery of care for all patients according to the Wagner's Care Model
- Patient Centered Care: Coordinate care in partnership with patient and family
- Enhanced Access– Provide convenient access not only through face-to-face visits but also via telephone, email, and other modes of communication
- Evidence Based Care: Adopt and utilize of evidence based care and decision support tools
- Self-Management Support: Help patients perform self-management and provide resources to do so
- Patient Tracking: Adopt and implement of health information technology to promote quality of care
- Performance Feedback: Participate in programs that provide feedback on the performance of the practice and the providers

Source: American College of Physicians, **The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care, 2006.**

Conclusion

- There is no “silver bullet”
- How best to compliment existing QI efforts in Oregon, and the policy mandate to change?
  - Further examine QI inventory to assess areas of overlap and categorize strategies
  - Build on existing alignment strategies
  - ‘Bricks & Mortar’ vs. ‘Virtual’ Institute?
- Importance of efficiency expectations
  - How is value defined?
- The importance of fundamental reimbursement change?
- Pilot studies and research can be important tools
  - But requires a longer time horizon

The Oregon Health Fund Board
Delivery System Committee Quality Institute Work Group
Vision for Health Care Quality and Transparency in Oregon
Approved _____

The Quality Institute Work Group of the Oregon Health Fund Board Delivery System Committee seeks to develop strategies to create a high-quality and highly transparent health care system in Oregon.

The work group endorses the following definitions of "quality" and "transparent:"

Quality
As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- Safe – avoiding injuries to patients from the care that is intended to help them.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered – providing care that is respectful of and responsive to individual patient preferences needs, and values and ensuring that patient values guide all clinical decisions.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The Agency for Healthcare Research and Quality has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

Transparent

A transparent health care system provides both medical and financial clarity in transactions among patients, doctors and hospitals, insurers and purchasers of health care[1]. This includes, but is not limited to, the public availability of easily accessible, clear, and comparable information about the quality and cost of care for services provided across health care settings. A transparent health care system provides consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services provided. In addition, it gives providers the tools and information necessary to compare their performance against the performance of other providers.

[1] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

Links to State-sponsored Hospital Report Cards:

State	Repository/Link	Type of data disclosed	Disclosure format
CA	CA Office of Statewide Health Planning & Dev. http://www.oshpd.state.ca.us/hqad/HIRC/hospital/index.htm *OSHPD produces risk adjusted outcomes studies that assess the quality of care provided by California hospitals. Administrative and clinical data collected by OSHPD are transformed into information that can effectively support better decision-making in health care.*	• Financial data • AHRQ volume and utilization • Heart Attack Outcomes • Community-acquired Pneumonia Care	Downloadable reports
	HMO and Medical Group Ratings http://www.opa.ca.gov/report_card/index.aspx *PAS surveys were done with more than 70,000 California patients between the ages of 18-64. All were patients who had a visit with a doctor in a medical group during 2005. Patients answered many questions about their experiences with their doctors and medical groups. Then, we organized the answers into five categories*	• HEDIS/CAHPS • Patient Assessment Surveys of physician experience	Interactive
FL*	FL Agency for Health Care Administration's State Center for Health Statistics http://www.floridahealthstat.com/healthstatcg.shtml	• Total hospitalizations (~141 medical treatments and surgeries) • AHRQ Inpatient Quality Indicators • Select AHRQ Patient Safety Indicators	Limited Interactive system and downloadable reports
MD	MD Health Care Commission http://hospitalguide.mhcc.state.md.us/ http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm	• Facility characteristics • Performance data - volume, LOS, readmissions (33 most common conditions) • Quality measures (8 CMS measures)	Interactive reports
NJ	NJ Department of Health and Senior Services http://www.state.nj.us/health/hcsa/	• Financial data • CMS Process Measures (AMI, HF, PNM, SIP) • AHRQ IQI Internal report/study • HEDIS/CAHPS	Interactive reports

*FL is in the process of expanding its consumer website to include additional information to facilitate facility comparisons.

State	Repository/Link	Type of data disclosed	Disclosure format
NY	NY State Department of Health www.health.state.ny.us/nysdoh/healthinfo/index.htm	• AHRQ CCS Volume Indicators • Composite CMS process measures • Cardiac outcomes/mortality	Downloadable reports Interactive map
PA	PA Health Care Cost Containment Council http://www.phc4.org/idb/HPR/ *Pennsylvania's Guide to Coronary Artery Bypass Graft (CABG) Surgery examines the results of approximately 13,360 CABG surgeries performed in Pennsylvania in the year 2004. This report includes outcomes on in-hospital mortality, 30-day mortality, 7-day and 30-day readmission rates and post-surgical length of stay. Hospital charges are reported as well.*	• Financial data • Performance data - volume, mortality rates, LOS, readmissions (~80 conditions) • Avg. charges • ***Includes surgeon level data for select conditions/procedures • Healthcare-acquired Infections in PA	Interactive system and downloadable reports
TX	TX Health Care Information Council http://www.thcic.state.tx.us/IQIReport2001/IQIReport2001.htm	• Hospital characteristics • AHRQ Inpatient Quality Indicators (~20 condition/procedures) • HEDIS/CAHPS • Top 25 APRDRG/DRGs by volume •	PDF
VA	VA Health Information http://www.vhi.org/ www.vhi.org/VAHosp.asp http://www.vhi.org/cardiac/vareports/asp	• Financial data and hospital characteristics • Cardiac outcomes (mortality/readmission) • HMO Reports • Volume, charge/cost by hospital • Physician data	Interactive system
WI	WI Department of Health and Family Services http://www.dhfs.state.wi.us/healthcarecosts/	• Financial data • Performance data - volume (~18-20 conditions/procedures) • Avg. charges	Interactive system
UT	Office of Health Care Statistics, Utah Department of Health http://health.utah.gov/myhealthcare/	• AHRQ Quality Inpatient Quality Indicators • Select AHRQ Patient Safety Indicators • Health plan quality information	PDF, Excel, web

*FL is in the process of expanding its consumer website to include additional information to facilitate facility comparisons.

State	Repository/Link	Type of data disclosed	Disclosure format
		•	
VT	Vermont Department of Banking, Insurance, and Health Care Administration http://www.bishca.state.vt.us/HcaDiv/hrap_act53/HRC_BISHCAcomparison_2006/BISHCA_HRC_compar_menu_2006.htm *These volume/mortality indicators were developed by the Agency for Healthcare Research and Quality (AHRQ)These particular procedures are shown because Vermont continued:* *research has demonstrated a link between the volume of the procedures and the outcome of the procedures, including mortality rates*	• AHRQ Quality Inpatient Quality Indicators • CMS Process Measures (MI, HF, PNM, SIP) • Provider CAHPS • Pricing and Financial	PDF, Excel
OR	Oregon Health Policy Commission and and the Oregon Office for Health Policy and Research http://www.oregon.gov/DAS/OHPPR/HQ/Resources.shtml	• AHRQ Quality Indictors	Static reports HTML and PDF
RI	Rhode Island Department of Health, Office of Performance Measurement http://www.health.ri.gov/chic/performance/quality/hospital1202.pdf	• CMS Process Measures	PDF
KY	Kentucky Cabinet for Health and Family Services healthdata.chfs.ky.gov *"The quality indicator reports presented on this web site were created using Inpatient Quality Indicator (IQI) software developed by the Agency for Health Care Research and Quality (AHRQ) and the Department for Health and Human Services (DHHS)."*	• AHRQ Quality Indicators • Volume and mortality by hospital	Interactive system

*FL is in the process of expanding its consumer website to include additional information to facilitate facility comparisons.

State	Repository/Link	Type of data disclosed	Disclosure format

MA	Massachusetts Division of Health Care Finance and Policy
	www.mass.gov/healthcareqc
	
	This website provides information about the quality and cost of health care provided in Massachusetts. Cardiac surgeon mortality and FY05 volume and quality reports now available.
	
	Many of the reports on this website are based on "administrative data," primarily used for billing for services provided. While administrative data cannot be used as the single source of information on health care quality, it can provide a picture of the medical care being delivered by hospitals.
		• AHRQ Quality Indicators
		  • Quality, Utilization, and Cost by hospital
		  • Volume by hospital and surgeon
		• Hospital Compare process measures
		• Cardiac measures, state-defined, administrative plus abstracted data
		• Link to Leapfrog measures for local hospital
			Static reports in Excel or PDF
			
			Excel or PDF

ME	Maine Quality Forum http://www.mainequalityforum.gov/ *"designed to create a balanced communication for the consumer. Consumers will be able to get a 360 degree view of the interpretation of the data, and make their own decision on how to use it or not use it". Employer Coalition*	• Utilization by hospital and service area • Quality, Morbidity by hospital and service area	Static charts and graphs

*FL is in the process of expanding its consumer website to include additional information to facilitate facility comparisons.

Select State Quality Improvement and Transparency Efforts
1/3/08 Draft – For discussion only

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states with the most developed health care quality improvement strategies.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank – nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

Maine Health Data Organization ***(MHDO)-*** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

Quality Counts **–** regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

Massachusetts Health Quality Partners ***(MHQP)*** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
    - Taking leadership role in building collaboration and consensus around a common quality agenda
    - Aggregating and disseminating comparable performance data
    - Increasing coordination and reducing inefficiencies to improve quality of care delivery
    - Developing and disseminating guidelines and quality improvement tools
    - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
    - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
        - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

***Buyers Health Care Action Group* (BHCAG) –** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group,** a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leafrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public purchasers (including Minnesota Department of Human Services) that have signed on as "Champions of Change" for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

***Minnesota Smart Buy Alliance* –** voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a "Coalition of Coalitions" – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer's Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:

- Adopting uniform measures of quality and results
- Rewarding "best in class" certification
- Empowering consumers with easy access to information
- Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

QCare – Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans
- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
  - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
  - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.

- **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
- **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
- **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
- **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
- **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done for complaint information by date, provider type, provider name, and the county or city where the provider is located.
- **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
- **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
- **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
- **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
- **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site

provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

***Pennsylvania Health Care Cost Containment Council* (PH4C)** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment
    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.
- Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

Wisconsin Hospital Association CheckPoint and Price Point **–** comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
    - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

Wisconsin Health Information Organization (WHIO) - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

Wisconsin Collaborative for Healthcare Quality ***(WCHQ) -*** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

OREGON HEALTH FUND BOARD
Delivery System Committee
QUALITY INSTITUTE WORKGROUP
ROSTER
2007

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OREGON HEALTH FUND BOARD
Delivery System Committee
QUALITY INSTITUTE WORKGROUP
ROSTER
2007

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Oregon Health Fund Board Delivery System Committee
Quality Institute Work Group Workplan
DRAFT FOR DISCUSSION 12/17/2007

OVERALL GOALS OF THE WORK GROUP

1. **Develop a "Vision for Quality" for Oregon under a reformed health care system**
2. **Identify roles for the state in supplementing and coordinating current quality improvement efforts to move towards this Vision**
3. **Make recommendations on how the state can most effectively and efficiently fulfill these roles**

DECEMBER 17 (2-5 pm, Northwest Health Foundation)
The first meeting will be focused on bringing members up to speed on work already being done in Quality Improvement arena in Oregon. The Work Group will identify gaps and shortfalls of current efforts and develop a "Vision for Quality" under a reformed health care system. The group will identify possible roles for the state in coordinating and supplementing current efforts to help Oregon realize this Vision.

Main Questions for Discussion:

- How were Quality Improvement and Transparency envisioned in SB 329?
- What was the Quality landscape in Oregon at the time SB 329 was crafted and how has it changed since?
- Where are we now - What does the current landscape look like?
- Where do we want to go - What does the Work Group envision for Quality Improvement under a reformed system?
- What is keeping us from getting there - What are the gaps and shortfalls of current quality efforts?
- What are possible roles for the state in filling these gaps?

JANUARY 3 (1-5 pm, Location TBD)
Before the second meeting, staff will work with the Work Group chair and vice-chair to create a "Vision for Quality" statement based on discussion at the first meeting. The Work Group will review/revise this statement at the second meeting and use it to frame subsequent decisions and recommendations. At this meeting, the Work Group will continue its discussion about the roles for the state in moving Oregon towards the Vision and begin to examine some of the specific tools or models the state might use to fulfill these roles. The group will be joined by Dennis Scanlon from Penn State, who is a national expert on quality improvement. Dr. Scanlon will help the group identify the strengths and weaknesses of other states' quality improvement efforts and draw lessons for Oregon. He will help the Work Group identify possible pitfalls of different approaches and ways to mitigate these challenges.

JANUARY 10 (1-5 pm, Northwest Health Foundation) and **FEBRUARY 5** (1-5, Location TBD)
The Work Group will develop specific recommendations on how the state can most effectively and efficiently coordinate and supplement work being done by other quality efforts in Oregon to move the state towards its "Vision for Quality." If possible, staff will bring in a facilitator for these meetings.

FEBRUARY 27 (if needed - 1-5 pm, Northwest Health Foundation)
The Work Group will finalize recommendations to send to the Delivery System Committee.

A Comprehensive Plan for Reform: Design Principles & Assumptions

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

VI. Reforms will build on the foundational elements of the current system.

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & ↓ COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → ↑ QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

H. - Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.
- A FHIAP-like program will serve Oregonians within defined income levels through premium subsidies.
- The Oregon Health Plan (Plus & Standard) will serve Oregonians below defined income levels.

I. New revenue (tax) options will be required

Oregon Health Fund Board
Delivery System Committee Charter
Approved by OHFB on :

I. Objective

The Delivery System Committee ("Committee") is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

The Committee's recommendation will serve as a cornerstone to the success of the Board's final report. The work of the Committee is framed by several principles and goals outlined in SB 329:

- *Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.*
- *Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability….*
- *Use proven models of health care benefits, service delivery and payments that control costs and overutilization….*
- *Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.*
- *Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year….*

The Board seeks, through the work of the Committee, more effective and efficient models of health care delivery that will address the health needs of all Oregonians through accountable health plans and other entities.

Bold and creative thinking is encouraged!

II. Scope

A. Assumptions:

In addition to the Board's *"Design Principles & Assumptions"* (attached), the Committee's work should be framed by the following assumptions:

1. While new revenue will be needed in the intermediate term to provide coverage to the currently uninsured, improving the performance of Oregon's delivery systems should provide opportunity to recapture or redeploy resources with consequent reduction in the annual rates of increase in health care costs.

2. The Committee's recommendations on system changes and cost containing strategies should apply to Oregon's delivery systems broadly, not solely to programs for the uninsured.

3. Proposed strategies for containing the rate of health care cost increases should include estimates of "savings" over a defined time period. Such projections will be used by the Finance Committee in the development of overall revenue requirements.

4. The following concepts are of priority interest to the Board:

- **Primary Care**

  Revitalizing primary care models to improve the capacity for and outcomes from preventive and chronic care services.

- **Managing Chronic Disease**

  Strategies for comprehensive, coordinated and sustained clinical management of the chronic diseases that significantly impact overall health care expenditures.

- **New Reimbursement Models**

  Strategies that move from fee-for-encounter (service) to financial incentives/rewards for providers who produce clinical outcomes that meet or exceed widely accepted standards of care.

- **Health Information Technology**

  Public policies and public-private collaborations that will increase the rate of diffusion and use health information technologies (e.g. electronic health records, registries, etc.) and ensure the interoperability of such technologies.

- **Information Transparency**

  Recommendations for a model Oregon Quality Institute that collects, measures and reports information on the performance of health care delivery systems including, but not limited to clinical quality and efficiency indicators. (See Oregon Quality Institute Work Group, below)

- **New Clinical Technologies**

  Recommendations to assure that the "added value" of new clinical technologies is broadly understood and that avoid inappropriate diffusion and utilization.

- **Public Health & Prevention**

  Strategies to develop, implement, sustain, evaluate and finance public health and public-private programs that target critical population health issues such as the obesity in Oregon's population.

- **End-of-Life Care**

Recommendations to improve end-of-life care that promote information about care options and advance directives, improve provider awareness of patient preferences and assure services for dignified care.

Note: The preceding list is not intended to limit the Committee's scope of investigation or recommendations.

B. Criteria:

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Does the recommendation improve the "value equation"? [Cost / Quality]

2. Does the recommendation contain the rate of growth of health care costs? Can the impact be measured objectively over time?

3. What is the anticipated timeframe for implementation?

- Short term? (1 to 2 years)
- Intermediate term? (3 to 5 years)
- Long term? (5+ years)

4. Does the recommendation require public policy action (statutory or regulatory)? Are the "politics" for such action: Favorable? Mixed? Unfavorable? Unknown?

5. Is voluntary collaboration among purchasers, providers, payers or consumers required to implement the recommendation? What is the "readiness" of key stakeholder groups to support such an effort?

C. Deliverables:

The Board anticipates receiving 5 to 10 recommendations from the Committee that address, in a strategic manner, the development of high-performing, value-producing health care systems. The recommendations may be prioritized.

Each recommendation should include, at minimum:

- A complete description of the recommended strategy and its intended objective(s).
- The method(s) for measuring the impact of the strategy over time.
- Estimates of "savings" achieved over a defined period of time through containing the rate of cost increases.
- The estimated timeframe for implementation with key milestones and risks.
- The impact of the strategy on key stakeholders.
- Reference citations to clinical or health services research relied upon in developing the recommendation.

III. Timing

The Committee will deliver its recommendations to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Physician	Portland
Vanetta Abdellatif	Multnomah Co. Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence BlueCross BlueShield of OR	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah Co. Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

V. Staff Resources

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848
- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

Oregon Quality Institute Work Group

Scope

In order to achieve a high-performing health care delivery system and contain cost increases, the State must work with providers, purchasers, payers and individuals to improve quality and transparency. The Oregon Quality Institute ("Institute") work group will make recommendations on the State's role in building on existing efforts to develop a public-private entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should an Institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should an Institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can an Institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should an Institute address issues of legal discovery and liability?
- What role can an Institute play in engaging Oregonians to use available data when making health care decisions?
- How can the State encourage more effective and coordinated value-based purchasing? How can the State strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and those served by the Oregon Health Plan?

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Work Group Membership

The Institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor's Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America's Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Nursing homes
Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project	Agency budget	Providers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers
The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers
Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Clinics serving vulnerable populations
Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Current and future health care providers

Organizations and Collaborative Initiatives Dedicated to Quality Improvement and Increased Transparency in Oregon
DRAFT FOR DISCUSSION - 1/9/2008

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by: (1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state (3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers
Oregon Health Policy Commission (OHPC)	THe OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is workging towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Providers, Purchasers, Vonsumers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Hospitals

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Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers and retail pharmacies in Oregon • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies; Grants	Consumers, Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Hospitals
Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must require participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and must have plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to physicians to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers

Other Initiatives

• Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

• The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans