

Colorado

Colorado is creating incentives for consumers to seek, and providers to deliver, the most cost-effective care by devising supportive health insurance benefits for consumers and payment mechanisms for providers. The state is adopting two strategies to meet this goal:

1. Adopt a statewide “Never Events” policy for non-payment to hospitals of those events as abstracted by HCPF from Centers for Medicare & Medicaid Services and National Quality Forum definitions; and
2. Make necessary changes in patient benefits and/or provider payment to incent the use of transition coaching and handover management during critical clinical events, transitions from a hospital inpatient setting to outpatient and vice versa.

Colorado is creating a process by which health care performance data are collected, standardized, evaluated, and made publicly available using the following four strategies:

- Identifying the current state and breadth of existing data by conducting a gap analysis to identify and classify what data and performance measures currently exist for priority areas.
- Assessing the value, consistency and clinical relevance of existing data to determine the extent to which they address the quality and performance of system providers.
- Determining the utility of quality measures to end users by conducting a pilot or series of pilot projects to aggregate, analyze and report quality indicators using agreed-upon evidence-based standards/criteria for quality improvement purposes.
- Determining the appropriate format to publish/disseminate the data by identifying and assessing existing dissemination tools and develop or modify existing tools to move toward a unified, consensus-based quality reporting agenda for all segments of the health care delivery system in Colorado including hospitals, physicians and health plans.

An Executive Order has created the Center for Improving Value in Health Care (CIVHC); SQII efforts have been modified to align with the goals of this new Center. The Center’s work will focus on aligning benefits and finances; engaging consumers; shared data/performance measures; and improving health care delivery. It has hired an interim director, and the four work groups are developing recommendations in collaboration for moving forward.

Kansas

SQII Status Report:

Kansas is working towards its goal of implementing medical home incentive payments/contractual rate adjustments in the State employee and Medicaid programs by 2010. Activity in Kansas to operationalize the medical home concept has intensified. All senior Medicaid managers have completed a review of their programs to ascertain the degree to which each encompasses medical home features. A national survey of states implementation of the medical home concept was undertaken and one of the All Stakeholders Medical home participants conducted provider interviews to determine the level of medical home readiness among Kansas providers. In addition, the Medicaid Transformation project, through which 14 Medicaid programs underwent a thorough program review, includes multiple recommendations for further integration of the medical home concept. To facilitate a broad stakeholder discussion about implementation of the medical home throughout Kansas, an All Stakeholders group, with broad based representation from the Kansas Medical Society, the Kansas Academy of Family Physicians, the Kansas Hospital Association, the Kansas State Nurses' Association, a foundation, multiple health insurers and health plans, mental health, health information technology, the Kansas Health Policy Authority (KHPA), and the Kansas Department of Health and Environment has met regularly to move the medical home concept to an implementation phase.

Kansas has recently released the baseline health indicators on Access to Care, Quality and Efficiency, Affordability and Sustainability, and Health and Wellness which are intended to help create a balanced State dashboard providing a snapshot of the status of health and health care in Kansas compared to national and state benchmarks. Included in those indicators are the two being measured in the Quality Institute project; child Medicaid enrollees with a medical home and hospital admissions for pediatric asthma.

Kansas has newly-created a HITECH Stakeholder group. This group will combine the efforts of the Medical Home Stakeholders, E-Health Advisory Council, and the HISPC group with the goal of positioning Kansas to compete for the grant funding available through the Federal American Recovery and Reinvestment Act (ARRA). This potential new funding source will quicken the implementation of the medical home concept during tight state fiscal times.

Massachusetts

Massachusetts is pursuing a multi-faceted approach that includes improvements in clinical care, public health and health policy (payment for, organization of, and delivery of services). The organizing framework for the State Quality Improvement Institute Action Plan relies on elements of the chronic care model and the medical home.

Massachusetts is adopting patient-centered primary care medical homes as a strategic approach to all of its state goals – from readmissions, to transitions in care, to HIT efforts. The charge to the SQII team is to formalize support for a statewide initiative. The Medicaid agency and EOHHS medical home planning team is currently developing a strategic proposal for the Massachusetts Medical Home Initiative. Phase 1 of the roll-out plan begins with community health center practices identified through the CMWF/QUALIS safety net medical home initiative as well as practices that care for a high volume of MassHealth Primary Care Clinician (PCC) plan members. The Medicaid agency plans to issue an RFR to procure practices to participate in the medical home initiative, which will include practice transformation, payment reform and measurement.

Massachusetts has also been selected as one of seven states in IHI's Commonwealth Fund project: *Reducing Re-hospitalization State Initiative*; the work of that group will help inform the SQII efforts. The SQI team put the IHI team in touch with the community health centers that are part of the QUALIS initiative to gain some synergy out of the two projects. IHI plans to target hospitals that are within the admitting regions of the CHCs in the QUALIS project. EOHHS is also working with 3M to develop a measure of potentially preventable readmissions and feed data back to hospitals in an effort to spur improvement in reducing avoidable admissions through a data-driven process. The Health Care Quality and Cost Council, another SQI team member, will publish the data on its consumer friendly website by hospital starting next year.

The goal the Massachusetts SQI team is to think strategically about how to knit together multiple, simultaneous cost and quality reform efforts to exact change at the system level, at which the medical home is core.



Health Reform Implementation Update May 2009

BACKGROUND: Minnesota was one of eight states that participated in Phase 1 of the Quality Institute (2008). Sponsored by the Commonwealth Fund and AcademyHealth, the Quality Institute was an opportunity for healthcare leaders in the state to gather and discuss quality improvement and payment reform. During the time the group began to meet, the 2008 Health Reform bill was signed into law. At that point, members of Minnesota's Quality Institute used the opportunity to discuss use of the Institute for Healthcare Improvement's Triple Aim as a basis for implementing the state's health reform efforts. The goals of the Triple Aim are to *simultaneously*:

- Improve the health of the population;
- Improve the patient/consumer experience; and
- Improve the affordability of health care.

Unprecedented collaboration among public and private partners – including consumers, patients, providers and payers – is critical to achieving these goals.

POPULATION HEALTH

While all of the reforms strive to improve the health of all Minnesotans, an integral part of the health reform law is the public health component, the Statewide Health Improvement Program (SHIP). The goal of SHIP is to help Minnesotans live longer, better, healthier lives by reducing the burden of chronic disease. SHIP will use effective, evidence-based strategies to create changes in policies, environments and systems to support healthy behaviors that reduce tobacco use and obesity.

- To implement SHIP, MDH has developed a competitive grant process and requirements for grantees.
- The RFP was released on February 9, 2009; proposals were due April 13, 2009. Grants begin July 2009.
- The applications received for SHIP grants cover 97 percent of the state.
- 39 applications cover all 53 community health boards and eight of 11 tribal governments in Minnesota.
- Grantees will be required to create community action plans, assemble community leadership teams, establish partnerships, and implement and evaluate interventions in order to make progress toward a set of process and performance measures.

MARKET TRANSPARENCY & ENHANCED INFORMATION

These reforms aim to improve the transparency of health care quality, cost and value in Minnesota, and to provide better information so that consumers, providers, purchasers and policymakers can make more informed decisions about health care. The goal of this transparency is to promote quality improvement, better management of chronic disease and more efficient resource use.

- **Statewide Quality Reporting System.** MDH has contracted with a consortium led by MN Community Measurement (MNCM) to develop recommendations for a set of standard quality measures and a set of quality measures for public reporting. After holding several public meetings in January and February, MNCM has submitted final recommendations for quality measures to be initially included in the statewide quality reporting system. The final recommendations are now available for review and public comment on the MDH Web site.
- **Provider Peer Grouping.** The peer grouping system will compare providers based on both quality and cost, offering more comprehensive information for consumers, providers, health plans and employers. The system will use the quality measures currently under development, as well as de-identified encounter data.
 - **Encounter Data.** MDH has contracted with the Maine Health Information Center (MHIC), a private nonprofit organization that collects encounter data on behalf of four other states, to design and implement Minnesota's encounter data collection system. MDH will work closely with the MHIC and with Minnesota stakeholders to facilitate the secure and efficient collection of de-identified data. As specified in the law, the encounter data will only be used as a source of data to

compare health care providers on a composite measure of cost and quality. After holding two public meetings and a comment period to obtain stakeholder input, a proposed rule establishing requirements related to collection of encounter data has been released.

- **Peer Grouping Methodology.** MDH solicited information and recommendations for the peer grouping methodology through a public Request for Information (RFI). Responses to the RFI and additional research will be synthesized into a set of issue papers. This information will inform the work of an advisory group that will be convened to make recommendations to the Commissioner of Health on the peer grouping methodology. The advisory group will begin meeting in June 2009. An RFP for the facilitation of the advisory group and a related technical panel has been issued and was due April 27.

PAYMENT REFORM

The law incorporates explorations in changing the way we pay for health care, with the goal of improving quality, reducing costs and promoting more consumer engagement in health care choices.

- **Quality Incentive Payment System.** The statewide quality incentive payment system will reward high-quality providers. MNMCM has submitted final recommendations for the quality incentive payment system measures and methodology. An Incentive Payment Work Group serves in an advisory capacity to MNMCM on work related to the development of the payment system. The work group functions as one of the mechanisms to ensure that the development of the payment system is a community-driven process. In that capacity, members will review and discuss the University of Minnesota's recommendations for designing an incentive-based payment system, and provide feedback and recommend changes as appropriate.
- **Health Care Homes.** A health care home is an approach to primary care in which providers, patients and families work in partnership to improve the health and quality of life of individuals with chronic or complex diseases. The concept involves coordinated care and continuous improvement. Providers will be reimbursed for care coordination, a service that adds comprehensive value, rather than only for specific procedures and tests. Work groups (representing 50+ stakeholders) convened to develop recommendations for certification standards. After soliciting public input, final recommendations were made to the Commissioners of Health and Human Services for consideration and decision. Expedited rulemaking has begun for a July 2009 deadline. Work has also begun to develop the payment methodology and learning collaboratives for health care homes.
- **Baskets of Care.** Baskets of care will bundle services together in ways that will create incentives for health care providers to cooperate and innovate to improve health care quality and reduce cost. The objective is to encourage providers, payers and consumers to think differently about health care service delivery by packaging related services together in a way that supports high-quality, lower-cost care. Baskets pull together health care services that are currently paid for separately, but are usually combined to deliver a full diagnostic or treatment procedure for a patient. The initial seven baskets will include diabetes, preventive care for children, preventive care for adults, asthma care for children, obstetric care, low back pain and total knee replacement. The Institute for Clinical Systems Improvement (ICSI) has contracted with MDH to facilitate the steering committee and seven subcommittees that will recommend detailed definitions for each basket of care.

CONSUMER ENGAGEMENT

Consumer engagement is a unifying theme across the programs. All aspects of the law will help empower consumers to be more proactive and knowledgeable about how health status and health care quality impact health care costs.

- **Consumer Engagement Initiative.** The legislation requires that MDH develop strategies to engage consumers around the issues of cost and quality in health care. MDH is looking at ways to embed discussions and awareness about these issues throughout the health reform efforts. MDH is exploring what incentives are needed to get consumers to act themselves or advocate for health system changes.

For more information: www.health.state.mn.us/healthreform

New Mexico

One of New Mexico's goals is building multi-stakeholder (e.g., health care professionals, health plans and other insurance companies, hospitals, consumer groups, patient advocacy groups, and business) coalitions to support on-going health care delivery innovations, public performance reporting, and financial incentive restructuring. New Mexico's action plan focuses on building local coalitions to support health care quality improvement and payment reforms, starting in the largest community, Albuquerque. Based on this multi-stakeholder engagement, the state will turn to a long-term agenda of performance measurement, and interventions focused on improving the care for diabetic patients and preventing diabetes among pre-diabetic patients. Piloting the use of the "medical home" concepts is one of several efforts expected in the coming year or two.

The state will address local quality improvement efforts aligned with its diverse population groups (e.g. multiple different language and cultural groups of American Indians, Latinos, and Asians). New Mexico anticipates the need for state-level health policy that addresses system delivery structure, supply and modernization that are responsive to local social, cultural and linguistic, and geographic differences across the state. The state's strategic plan relies on developing a vibrant quality improvement coalition in Albuquerque where the majority of the state's population resides and the health plan and service providers are largely located and operate. Rural and frontier areas will be the subject of special efforts.

Ohio Health Quality Improvement Plan Executive Summary

Ohio’s involvement in the Commonwealth Fund/Academy Health State Quality Improvement Institute has resulted in a comprehensive process to engage stakeholders in developing a plan to transform Ohio’s health care system. In November 2008, more than 180 health care providers, business leaders, government officials and health advocates interested in pursuing health system reform participated in the Ohio Health Quality Improvement Summit. During this three-day event, those attending developed twelve strategies for creating a high-quality, cost-effective, high-performing health system in Ohio by 2013.

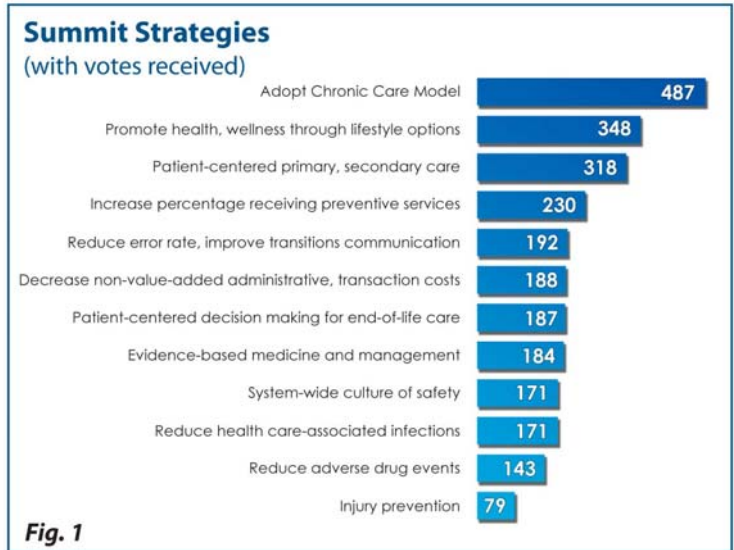


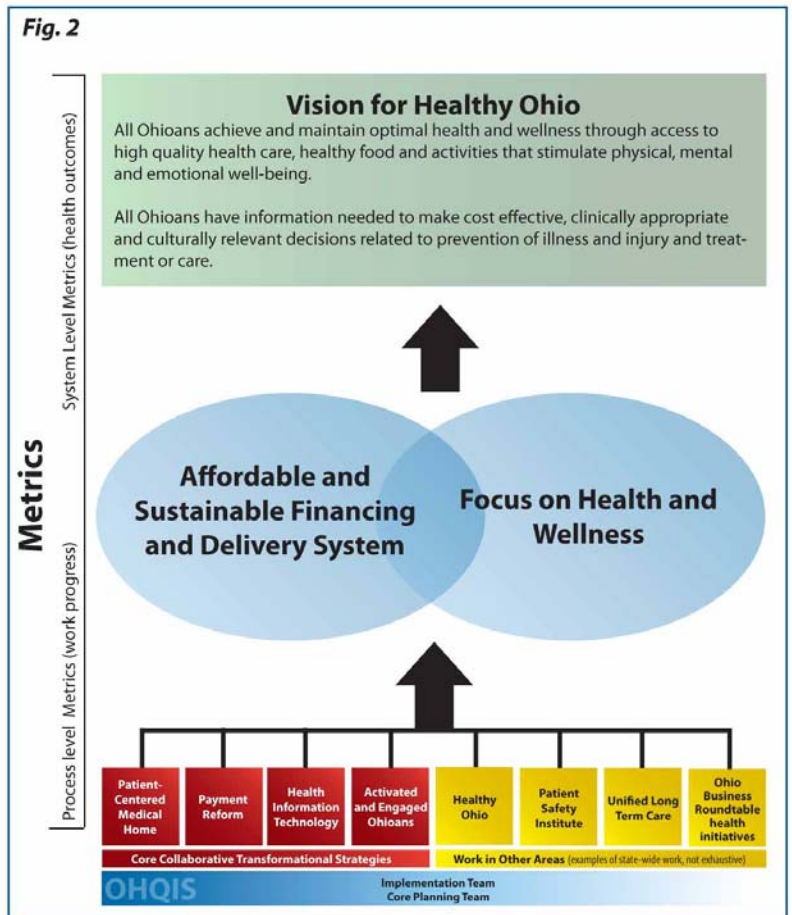
Fig. 1

Since the Summit, a number of participants have used the summit strategies and subsequent activities to develop the Ohio Health Quality Improvement Plan (OHQIP). In April 2009, more than 160 people participated in a second Summit, where a draft of the OHQIP was presented. Hundreds of people have provided input throughout the process. Both the report from the Summit and the current version of the OHQIP can be downloaded at <http://ohqis.pbwiki.com/Report>. The Plan will be finalized by June 3, 2009.

In creating the OHQIP, the Core SQII Team decided to refocus its attention from the 12 summit strategies to 4 core collaborative transformational strategies (CTS):

- Patient-centered medical home
- Payment reform
- Health information technology; and
- Activated and engaged Ohioans.

Figure 2 is a graphical representation of the relationship between the “building block” initiatives and how that work could lead to



achieving the Vision for Healthy Ohio. To confirm that these four collaborative strategies would support the success of the 12 Summit strategies, the core team created a crosswalk between these two groups of strategies (see figure 3 below), as well as other key state level initiatives.

Fig. 3

Summit Strategies (listed in order of votes received)	Core Collaborative Transformational Strategies				Work in other areas (Examples of state-wide work, not meant to be exhaustive)			
	Patient Centered Medical Homes	Payment Reform	Activated/Informed Patients	Health Information Technology	Healthy Ohio	Patient Safety Institute	Unified Long Term Care	Ohio Business Roundtable health initiatives
Chronic Care Model	✓	✓	✓	✓	✓		✓	
Culture of wellness	✓	✓	✓		✓			✓
Patient-centered primary care	✓	✓	✓	✓				
Clinical preventive screenings	✓	✓	✓	✓	✓			
Reduce errors during hand-offs	✓	✓		✓		✓	✓	
Decrease non-value-added admin costs		✓		✓				
Patient-centered end-of-life decisions	✓		✓				✓	
Evidence-based medicine	✓	✓	✓	✓				
System-wide culture of safety		✓	✓			✓		✓
Reduce health care-associated infections		✓				✓		✓
Reduce adverse drug events	✓	✓	✓	✓		✓		✓
Injury prevention	✓		✓		✓			

The Core SQII Team recommends system level outcome measures to help focus attention on the goal of creating a high-quality, cost-effective, high-performing health system in Ohio by 2013. In developing the system measures, the team recommends using a balanced scorecard approach, with measures in five different areas to determine success. The proposed areas are: quality; access; wellness; health spending; and satisfaction (provider and individual). In addition, any metrics identified would be designed to ensure that geographic, racial and other disparities are being addressed.

The final determination of system-level measures will require additional discussion and shared commitment, as well as the identification of data sources, baseline measures, and attainable yet aggressive performance targets and timeframes.

Concurrent with this Plan’s development, Governor Ted Strickland announced the establishment of the Ohio Health Care Coverage and Quality Council, which was created through Executive Order in February 2009. The Council, which will include over 30 members from diverse perspectives, is charged with advising the Governor and General Assembly on improvements to health programs and policies; monitoring and evaluating implementation of strategies for increasing access and improving quality of the health care system in Ohio, and cataloging existing health care data reporting efforts, among other responsibilities. The recommendations contained in the Ohio Health Quality Improvement Plan will be presented to the Council at its first meeting (tentatively to occur in June 2009), with the expectation that the Council and its members will act to facilitate the implementation of these recommendations, continue to incorporate tactics addressing the issues of disparities and workforce capacity, and propose other initiatives to transform and create a high performance health care system in Ohio.

Oregon

Oregon's state agencies that administer health insurance, health care, and public health programs are working together to align quality efforts in connection with the many private sector efforts underway in the state. Oregon recognizes that aligning quality efforts across these agencies and programs promises to improve the health quality of program participants as well as create leadership and momentum for health reform for all Oregonians.

A State Health Quality Improvement Team has been actively working to create a State Agency Health Quality Action Plan. The overarching goals of the action plan are to use state purchasing power, oversight, and partnership opportunities to move Oregon toward:

1. Drastically reduced chronic disease, obesity, and tobacco use among Oregonians through prevention in the community and medical setting.
2. A health system in which all Oregonians have access to an integrated health home, with a focus on primary care, prevention, and chronic disease management.
3. A health care delivery system in Oregon that is the safest in the country.

A fourth goal of the State Agency Action Plan is to support the above work by establishing an agreed upon set of metrics in order to drive quality improvement and evaluate the impact of quality efforts.

This state agency quality alignment work is viewed as one piece in what is envisioned for an Oregon Quality Institute. Over the last two years, Oregon conducted an extensive health reform planning process under the leadership of the Oregon Health Fund Board (OHFB). Currently the Oregon Legislature is considering legislation supported by the OHFB work that would realign health care functions in Oregon state government under an Oregon Health Authority and, among other reforms, support the creation of an Oregon Quality Institute to serve as a forum for supporting and aligning quality efforts statewide.

The Oregon Health Policy Commission currently provides oversight for the development of the State Quality Action Plan, providing a public forum for discussion and refining the plan. If created, it is likely that the Oregon Health Authority would assume oversight of the action plan going forward.

Vermont

Beginning in July, 2008, Vermont began a pilot program for the Blueprint integrated medical home model in 3 communities. The Vermont team is charged with implementing this project linking it to other health initiatives in the state, and monitoring its success. Vermont will also identify strategies to enhance the likelihood that the integrated pilot model will be sustainable. Currently, Vermont has two of its medical home pilot communities underway; the third will begin in February or March. At that time, ten percent of the state's population will be enrolled in these integrated pilots.

Vermont is seeing a good integration in these pilot communities with behavioral health issues, and the community care teams are working well. The challenge is to have robust enough evaluation in order to demonstrate that the pilots are delivering value.

Washington State Quality Institute Team Leader Update #6: May 15, 2009

1. What is the latest progress your state team has made in its quality improvement efforts?

Washington's Quality Institute team efforts, focused on the concept of a patient-centered medical home, have fallen generally under one of the three policy levers identified in our original proposal.

a. Expand patient-centered medical homes

- *Training for Physician Practices:* The Washington Patient-Centered Medical Home Collaborative has launched enrollment for up to 24 primary care practices. More than 50 practices have indicated interest to join the Collaborative, but the 2009 legislature discontinued funding targeted for this effort in response to Washington's budget crisis. As a result the number of practices that will be trained has been reduced from 40 to 24. Collaborative funding now relies on public-private co-sponsors that include (1) the Diabetes, Heart Disease, Asthma, Cancer, Tobacco and Rural Health Programs at the Department of Health; and (2) the Washington Academy of Family Physicians and First Choice Health Network, through their Improving Performance in Practice program and Washington Health Information Collaborative program, respectively. Participating practices will be selected in early June to begin pre-work for a first Learning Session in September.

A five part evaluation design is being created encompassing (1) the degree of implementation of the medical home concepts, (2) patient/family experience, (3) provider satisfaction, (4) clinical practices changes in 3 chronic diseases (diabetes, asthma and heart disease) as well as preventive health services, and (5) changes in cost and utilization data. The latter will be evaluated through the University of Washington if funding can be identified.

b. Develop payment strategies to support medical homes

- *Reimbursement Pilots:* Governor Gregoire has signed into law new legislation that directs State agencies to continue their previous work through the actual design and implementation of one or more primary care medical home reimbursement pilots. The new law (<http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202009/5891-S.SL.pdf>) is intended to provide some anti-trust protection to enable multiple private payers to join the State in its work and participate in shaping a multi-payer reimbursement pilot. The Puget Sound Health Alliance is supporting the State in this work by helping to convene numerous stakeholders including health plans, purchasers and providers. An initial meeting has been scheduled.
- *Initiating the Work:* Formal invitations recently went out to sixteen organizations and/or individuals to invite their participation in a multi-payer reimbursement pilot. An initial meeting of this group is planned for late June.
- *Link with Other States' Work:* The Alliance has completed a compendium that summarizes the status of other multi-payer demonstrations around the country (as of April 2009) as a reference for the work going forward.

c. Develop communication strategies for engaging consumers

- *Puget Sound Health Alliance Reporting:* The Alliance has just released its Community Checkup performance results by payer type and has worked closely with the State Medicaid program in this endeavor. Results are available now on www.CommunityCheckup.org. The report includes ambulatory quality measures by medical group by payer type (commercial, Medicaid fee-for-service, and managed Medicaid). The Alliance will be releasing its third Community Checkup report in July 2009.

- Shared Decision-Making Demonstrations:* Progress by the Shared Decision-Making Collaborative Stakeholder Group (Collaborative) - which includes representatives from the PSHA, University of Washington (UW), Group Health Cooperative (GH), Washington State Medical Association (WSMA), Virginia Mason, The Everett Clinic, Multi-Care and the Carol Milgard Breast Center - continues along 2 complementary paths. Both include fairly comprehensive evaluations of the impact of Patient Decision Aids on improving patient decision quality (increase knowledge and understanding of values, reduce decisional conflict) and reducing unwarranted variation in health care (variation that is not explained by disease or condition).

(a) Group Health is implementing decision aids for 13 preference-sensitive conditions related to elective surgical procedures, and PSA screening. Group Health's Center for Health Studies is conducting the evaluation with funding from several major sources, including the Commonwealth Fund, the Foundation for Informed Medical Decision-Making (FIMDM), and the Group Health Cooperative Foundation. Group Health's demonstration project is assessing impact of patient decision aids on decision quality, use of related health care, and cost.

(b) UW researchers recently were awarded a grant funded by FIMDM to pilot and evaluate shared decision-making and patient decision aids in 4 progressive multispecialty group practices. This work complements the Group Health initiative in a fee for service environment, focusing on a narrower set of procedures. The UW pilot is designed to evaluate the *process*, answering questions regarding the challenges and experiences of purchasers, payers, providers, and patients in implementing shared decision-making and patient decision aids. For example: Did the right patients get PDAs? Did patients actually use (e.g., view) their PDAs? Did these patients and their physicians use a shared decision process that accounted for the patient's values to arrive at a decision? What did providers find useful or difficult, etc.
- Regional Variation Research:* Discussions are occurring among public program clinical, research, and policy staff on the results of a growing body of Washington-based *system-level* variation analysis. Regional variation in a variety of inpatient surgeries, ambulatory care-sensitive conditions (which represent potentially avoidable hospitalizations) and resource capacity has been identified. Discussions highlight areas where additional variation analysis would be helpful (e.g., low back fusion). They have also raised the need for a more coordinated link between *program-related* research that is often more "granular" than the high-level *system-related* research directed by the Legislature. Conversations to translate the research into meaningful action are an ongoing challenge.

Initial efforts to understand the regional distribution of Washington's health facilities have culminated in a preliminary web-based query system (<http://wa-state-ofm.us/FacQ/>) that consolidates existing public information about facilities and highlights major gaps in information needed to fully understand the availability and potential future need for health resources.