Oregon

Oregon Health Fund Board
1st Floor, General Services Bldg
1225 Ferry St., SE
Salem, OR 97301
(503) 373.1779
Fax 503-378-5511

To: Members of the Oregon Health Fund Board
From: Members of the Oregon Health Fund Board Delivery Systems Committee
Subject: Quality Institute Work Group Report to the Delivery Committee
Date: April 23, 2008

On April 17, 2008 the Delivery Systems Committee received the enclosed report from its Quality Institute Work Group. The Committee agrees that ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system and must be a central focus of any health reform plan. A single entity is needed to set the quality agenda for Oregon and lead and unify existing quality initiatives in a collaborative effort to move the state toward a higher performing health system. Therefore, the Delivery Systems Committee endorses the recommendations, but suggests that the Board consider the following issues before making final recommendations. The points below reflect suggestions made by Committee members during the April 17 meeting.

- **Clarify and strengthen language about aligning stakeholders around common quality metrics and setting standards for data collection and reporting**. The Quality Institute should set standards for what metrics are collected and reported and how data is collected and reported. Standards should aim to simplify and streamline processes, allow for meaningful comparisons across the health care system and reduce administrative costs associated with reporting different sets of measures to different purchasers and health plans. In addition, the Quality Institute should set performance benchmarks that can be adapted over time.

- **Efforts of the Quality Institute must support and be aligned with Accountable Care Districts and reform evaluation.** The data collected and reported by the Quality Institute should support performance evaluation within the healthcare system, but must also support community evaluation of performance. The Quality Institute should report data in a way that allows for meaningful comparisons across communities and accountable care districts. In addition, the Quality Institute must collect and report data that aligns and supports efforts to evaluate state funded health programs and health care reform.

- **Providing understandable and meaningful information about quality to consumers must be a priority.** "Understandable" should be added to the definition of transparency to reflect the need to ensure that public reporting be done in a way that is meaningful to lay persons. Recommendations should be reordered to put more of an emphasis on

the need to engage and support consumers in quality improvement initiatives.

- **The recommended structure should be revisited after a comprehensive plan is developed.** Members questioned whether there would be a need for a separate and distinct Quality Institute with all of the entities created through reform. Members also suggested that the Board assess the role of private stakeholders in the public-private structure and suggested that these stakeholders provide specific testimony as to how a Quality Institute could enhance current efforts.
- **Greater transparency around cost is vital to reform and cost containment efforts.** The Delivery Committee did not necessarily recommend that the Quality Institute should take a more significant role in reporting data associated with costs than was recommended by the Work Group, but suggested that cost transparency needs to be addressed throughout the reform process.

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

April 10, 2008

[THIS PAGE INTENTIONALLY LEFT BLANK]

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

[THIS PAGE INTENTIONALLY LEFT BLANK]

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

Report Index

Preamble……..4

I. Background……..4

II. Recommendations for an Oregon Quality Institute ….....5

III. Logic Model…….8

IV. Work Group Process…..……10

V. Definitions of Quality and Transparency……11

VI. Problem Statement……..12

VII. Assumptions…….13

VIII. Roles for a Quality Institute……14

IX. Funding, Structure and Governance…….19

X. Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon…….20

XI. Appendix B: Select State Quality Improvement and Transparency Efforts……...27

XII. Appendix C: Quality Institute Budget……..40

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.

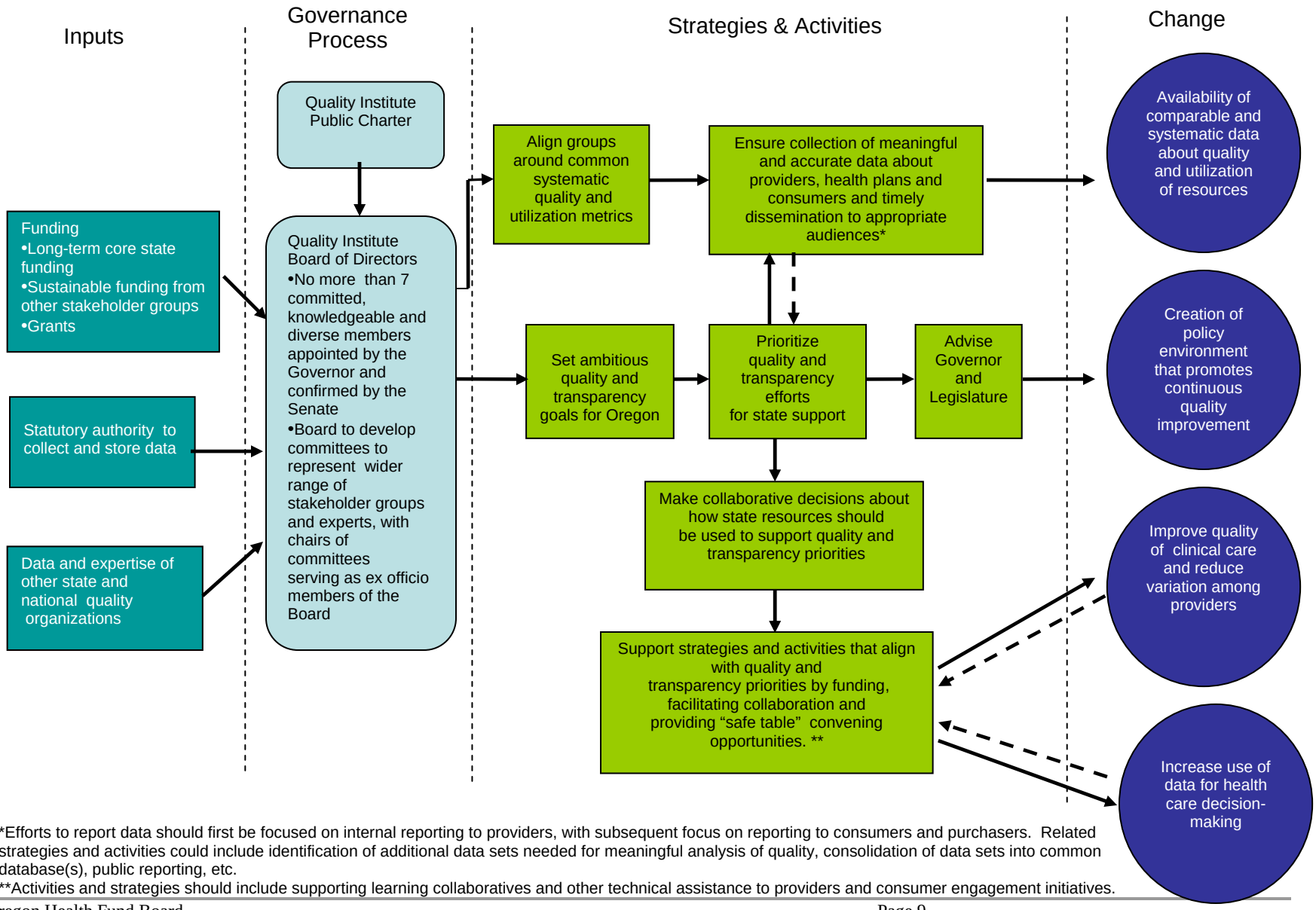
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

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.