



**Network**  
for REGIONAL  
HEALTHCARE  
IMPROVEMENT

# Regional Health Improvement Collaboratives Going Forward

*By Karen Wolk Feinstein, PhD, President and CEO,  
Pittsburgh Regional Health Initiative; NRHI Board Member*

**We have assembled this edition of *ROOTS* to consider the essential role of Regional Health Improvement Collaboratives (RHICs) in health reform as the nation goes forward into a new Administration. Over the last decade, RHICs have played a critical role in advancing quality improvement and cost containment through public reporting and transparency, demonstrating improvements through the application of Lean methods, advancing local experimentation with new delivery and payment models, and advocating for better prevention and health promotion strategies. Importantly, RHICs turned these strategies into a movement for better health care by assembling local stakeholders, promoting an understanding of the failures of our systems, sharing best practices to improve outcomes of care, and promoting effective leadership for health improvement. These actions, though regional, gained the attention of the federal government and helped shape a decade of national policy reforms and federally-funded experimentation.**

The construction of a national policy framework, however, does not mean that regional innovation is no longer important. In fact, it is probable that the locus of energy, innovation, and progress will devolve to the local and state levels. Now is perhaps an ideal time for RHICs to become more active—as uniquely nonpartisan coalitions of all stakeholders who, even if they aren't in total agreement about the means for reform, are totally aligned about the need. Indeed, the various Collaboratives were both a product of a common recognized need for reform, as well as an impetus for the tremendous national policy changes that have occurred over the past decade.

What is critical now is to bring more momentum for positive change to the frontlines of care. This is where safety, best practices, waste reduction, complication prevention, teamwork, rapid problem solving, performance excellence, patient satisfaction, and seamless care begin. Now, as the imperative is to 'get granular,' to reconsider how care is delivered locally, by whom, and in what settings, there is an opportunity for regional consensus organizations to renew and expand their role.

Over the past decade, from 2006 to 2016, 30-40 RHICs have benefitted from their national organization, the Network for Regional Healthcare Improvement (NRHI), which helped position individual members to also serve as, or contribute to, Regional Extension Centers, Beacon Community Cooperatives, Qualified Entities, Aligning Forces for Quality

entities, Hospital Engagement and Quality Improvement Networks, and State Improvement Model leadership. Working in partnership, various RHICs have been prime recipients of large grants from the Center for Medicare and Medicaid Innovation and the Agency for Healthcare Research and Quality. Skills honed through these engagements equipped RHICs to discover and experiment with new care and payment models; research best practices and system failures; train health workers for new roles and new requirements; inform and empower consumers and purchasers with information and data; integrate mental health services into primary care; and train providers in waste reduction, safety and Lean quality engineering, and conversations at the end of life.

In the years ahead, Regional Collaboratives aligned through NRHI can accelerate local change and maintain the progression of health reform. NRHI helps RHICs share best practices, pool their particular areas of expertise, work in partnership, and communicate collectively where appropriate to their boards, federal funders, and the public. In the pages that follow, we highlight the expertise, accomplishments, and critical roles played by many Collaboratives, as well as by the Network for Regional Healthcare Improvement. Their stories are both a testament to their scope and diversity, and a call to action.

In an era of extreme (and often dysfunctional) partisanship, RHICs work to achieve broad community consensus around worthy healthcare improvements goals: saving lives, saving money, strengthening local institutions. The work of reform is far from over, but the regional engines are fragile. It is imperative that the time-limited funding sources of the last decade be replaced with new resources to guarantee sustainability.

I am hoping that you will conclude with us that ‘if Regional Collaboratives and our national Network didn’t exist, we would need to invent them.’



(L-R) Peter Lee, Mark McClellan, Elliott Fisher, Karen Wolk Feinstein; NRHI Payment Reform Summit - 2007



# Critical Timeframe in the Regional Health Reform Movement

**1973**

Managed Care Act established: stimulates growth of HMOs to reduce costs and promote prevention

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**1974**

National Business Group on Health forms to contain healthcare costs

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**1984**

Agency for Healthcare Research and Quality created

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**1985**

Brent James, MD, of Intermountain Healthcare develops national training center

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**1988**

Jack Wennberg, MD, founds Dartmouth Institute for Health Policy and Clinical Practice to investigate variations in cost, outcomes, and service utilization

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**1989**

Pacific Business Group on Health forms

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**1990**

James Reason's *Human Error* introduces modern error analysis to medicine

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**1991**

Institute for Healthcare Improvement forms

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**1993**

Institute for Clinical Systems Improvement founded in Minneapolis

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**1994**

*Boston Globe* healthcare columnist Betsey Lehman dies at Dana-Farber Cancer Institute from massive chemotherapy overdose; two weeks later, Lucian Leape, MD, publishes *Error in Medicine*

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Ken Kizer, MD, named head of U.S. Department of Veterans Affairs and oversees quality transformation

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Centers for Medicare & Medicaid Services publishes report on National Health Expenditures, raising more alarm about escalating costs

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**1995**

Massachusetts Health Quality Partners founded

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**1997**

National Patient Safety Foundation established

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Ed Wagner, MD, develops Chronic Care Model, advancing care management

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Pittsburgh Regional Health Initiative founded

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**1999**

Institute of Medicine publishes *To Err is Human*, estimating that 44,000 - 98,000 Americans die needlessly each year from medical error

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Michael Millenson publishes *Demanding Medical Excellence* revealing flaws in U.S. health care

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**2000-2003**

Harvard Business School publishes Beth Israel Deaconess case study about Toyota industrial engineering processes in a hospital

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CDC and Agency for Healthcare Research and Quality fund major infection reduction demonstrations in Pittsburgh with PRHI; region reduces central line infections by 68%

Robert Wood Johnson Foundation funds new regional quality coalitions and quality improvement demonstrations, and later a RAND study on regional quality collaboratives

Rewarding Results: Aligning Payments with High-Quality Health Care funded by Robert Wood Johnson Foundation and the California Health Care Foundation to test the use of financial incentives to improve the quality of health care

RAND study, *Quality of Care Delivered to Adults in the United States*, by McGlynn et al, highlights inadequacy of best practices in primary and preventive care

Rosemary Gibson publishes *WALL OF SILENCE: The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans*

Two publications, *Complications*, by Atul Gawande, MD, and *Escape Fire*, by Don Berwick, MD, ignite interest in safety and quality concerns

[Oregon Health Care Quality Corporation, Healthy Memphis Common Table, Kansas City Quality Improvement Consortium, California Quality Collaborative, P2 Collaborative of Western New York and Quality Counts \(Maine\) are founded](#)

## 2004

Porter and Teisberg publish *Redefining Competition in Health Care* in Harvard Business Review, advocating value-based competition in health care

Robert Wachter, MD, publishes *Internal Bleeding: The Truth Behind America's Epidemic of Medical Mistakes*

[Wisconsin Collaborative for Healthcare Quality, Iowa Healthcare Collaborative, and Puget Sound Health Alliance are founded](#)

## 2005

Four emerging Regional Health Improvement Collaboratives meet in Minnesota to discuss quality improvement opportunities

[Minnesota Community Measurement incorporated](#)

Steven Spear publishes *Fixing Healthcare From the Inside* in Harvard Business Review

## 2006

California Health Care Foundation invites broader group of quality improvement collaboratives to meet for two days in San Francisco; 80 leaders from 40 organizations in 17 states represented

[Network for Regional Healthcare Improvement formally established](#) with funding from the Robert Wood Johnson Foundation, the California Health Care Foundation, and Jewish Healthcare Foundation

## 2006

Robert Wood Johnson Foundation launches Aligning Forces for Quality, supporting regional collaboratives

## 2007

Commonwealth Fund publishes *Multinational Comparisons of Health Systems*; awakens U.S. to high cost and low quality of health care

The Network for Regional Healthcare Improvement holds a one-day, invitation-only national Summit on Creating Payment Systems to Accelerate Value-Driven Health Care

[Health Improvement Collaborative of Greater Cincinnati achieves Aligning Forces for Quality status and forms Health Bridge, an electronic Health Information Exchange](#)

## 2008

U.S. Department of Health and Human Services Secretary Michael Levitt establishes a national coalition of regional health improvement collaboratives by officially designating a number of Chartered Value Exchanges (CVE), housed at the Agency for Healthcare Research and Quality

The Network for Regional Healthcare Improvement holds its second Payment Reform Summit

## 2009

[Jewish Healthcare Foundation establishes Center for Healthcare Quality and Payment Reform](#); Harold Miller circulates seminal article on payment reform, *From Volume to Value*

Reuters study estimates that the U.S. healthcare system wastes between \$505-\$850 billion per year

The Office of the National Coordinator for Health Information Technology (ONC) is created to build an interoperable, private and secure nationwide health information system and to support meaningful adoption of health information technology (HIT)

ONC selects 62 Regional Extension Centers (RECs), including RHICs, throughout the country to assist primary care providers in the adoption and meaningful use of electronic health records

## 2010

Patient Protection and Affordable Care Act (PPACA) passes

Milliman study finds that medical errors cost the U.S. economy \$19.5 billion per year

Regional Health Improvement Collaboratives play prominent roles in the Office of the National Coordinator of Health Information Technology Regional Extension Center and Beacon Community Cooperative Agreement Programs

## 2010

The Agency for Healthcare Quality and Research (AHRQ) launches a three-year initiative to spread the evidence-based Partners in Integrated Care (PIC) model to screen primary care patients for depression and/or unhealthy substance or alcohol abuse and support patients with a care team

## 2012

CMMI launches the State Innovation Model (SIM) initiative, providing federal grants to states to design and test innovative, state-based multi-payer healthcare delivery and payment systems

CMMI awards an Innovation Challenge grant to Institute for Clinical Systems Improvement (ICSI) called Care Management of Mental and Physical Co-Morbidities (COMPASS), which provides training and coaching to care managers and healthcare teams better manage complex care

## 2013

NRHI launches the multi-regional Total Cost of Care (TCoC) Initiative with five pioneering RHICs to produce, share, and use information about the total cost of care

## 2014

The Collaborative Health Network is established to ensure that a broad network of individuals and organizations learn about and apply the multi-stakeholder approach

## 2015

NRHI and the Pacific Business Group on Health launch The Center for Healthcare Transparency, an initiative to provide meaningful cost and quality information to patients, providers, and purchasers to enable value-based healthcare decision-making

## 2016

NRHI hosts its third National Payment Reform Summit in Washington, DC

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## Regional Health Improvement Collaboratives: the Foundation for Ongoing Healthcare Reform

*By Harold D. Miller, President and CEO of the Center for Healthcare Quality and Payment Reform; Former President and CEO, Network for Regional Healthcare Improvement*

### The Need for Regional Health Improvement Collaboratives

**One of the greatest challenges facing the nation is how to make the American healthcare system more affordable while maintaining and improving its quality. Although many people believe costs cannot be reduced without rationing care, the evidence is clear that healthcare costs can be significantly reduced while improving quality, such as through prevention of illnesses; avoiding unnecessary and potentially harmful tests, interventions, and medications; eliminating harmful and expensive infections and medication errors; and educating patients with chronic disease about how to manage their conditions and prevent the need for costly hospitalizations.**

However, there are also many barriers that have prevented these opportunities for reducing costs and improving quality from being realized. For example:

- Patients (and healthcare providers who are trying to advise them) cannot get the data on quality and costs they need to choose the highest-quality, highest-value providers and services;
- Doctors, nurses, and other healthcare professionals typically do not have the kind of training or experience needed to redesign care processes in order to improve quality and reduce costs;
- Health plans and government programs fail to pay for many high-value services and often financially penalize physicians, hospitals, and other healthcare providers for reducing infections, errors, complications, and unnecessary services;
- The fragmented structure of healthcare providers and the lack of efficient methods of sharing information among them makes it difficult to coordinate care for patients; and
- Health plan benefits are often not structured in ways that enable and encourage consumers to improve their health, adhere to treatment plans, etc.

“At the Robert Wood Johnson Foundation we believe change happens at the community level, and that sharing data about health and health care can help the people who give, get, and pay for care achieve better outcomes and lower costs. Through my many experiences working with NRHI over the years, I’ve learned a great deal about how communities work with data, build trusting and effective relationships among stakeholders, and establish a business case for change.”

Anne F. Weiss, Managing Director - Program, Robert Wood Johnson Foundation

Clearly, if healthcare reform is to succeed, multi-faceted approaches are needed to overcome all of these barriers in a coordinated way. Such approaches will, by necessity, be different in different parts of the country; the significant differences across the country in the structure of health care and in the specific types of cost and quality problems in each community discourage any one-size-fits-all national solution.

Moreover, since all of the healthcare stakeholders in a community – consumers, physicians, hospitals, health plans, businesses, government, etc. – are affected in significant ways, they all need to be involved in planning and implementing changes. In many communities there is considerable distrust between different stakeholder groups, so a neutral facilitator is often needed to help design “win-win” solutions.

Regional Health Improvement Collaboratives (RHICs) have served as an ideal mechanism for developing coordinated, multi-stakeholder solutions to healthcare cost and quality problems. A RHIC does not deliver healthcare services directly or pay for such services; rather, it provides a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system.

Regional Health Improvement Collaboratives have three key characteristics:

- They are non-profit organizations based in a specific geographic region of the country (i.e., a metropolitan region or state);
- They are governed by a multi-stakeholder board composed of healthcare providers (both physicians and hospitals), payers (health insurance plans and government health coverage programs), purchasers of health care (employers, unions, retirement funds, and government), and consumers; and
- They help the stakeholders in their community identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities.

In 2010, there were more than 40 Regional Health Improvement Collaboratives in the country. Many had been formed relatively recently, but some were in existence for 20 years or longer. There has been dramatic growth in the number of Regional Health Improvement Collaboratives in the recent decades, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts by the Robert Wood Johnson Foundation (through the Aligning Forces for Quality program) and the U.S. Department of Health and Human Services through the Chartered Value Exchange program to encourage creation of these kinds of entities. The leading Collaboratives are members of the Network for Regional Healthcare Improvement, which is the national association of Regional Health Improvement Collaboratives.



# The Roles Regional Health Improvement Collaboratives Play

**Regional Health Improvement Collaboratives help their communities to deliver higher-quality, more affordable health care in many different ways. Five of the most important roles they are playing across the country are measuring health system performance, facilitating payment and delivery system reform, providing training and assistance to providers, educating consumers, and helping to plan and coordinate health improvement activities.**

## **1. Performance Measurement**

It is a well-known principle that “you can’t manage what you can’t measure.” In the case of healthcare reform, communities need the ability to identify opportunities for reducing costs and improving quality and to monitor whether those opportunities are being successfully addressed. Regional Health Improvement Collaboratives can serve as neutral, trusted sources of actionable information about the cost and quality of healthcare services, the health of the population, and/or the extent to which state-of-the-art methods of delivery, payment, and health promotion are being used in their communities.

Regional Health Improvement Collaboratives across the country are publishing reports on many aspects of the quality and cost of care that are not available to either the public or healthcare providers through any other source. These measurement and reporting initiatives are developed and operated with the active involvement and supervision of the physicians and hospitals whose performance is being measured, so those providers can ensure that the measures are meaningful and the data are accurate. This, in turn, increases the willingness of healthcare providers to change care processes in order to improve their performance.

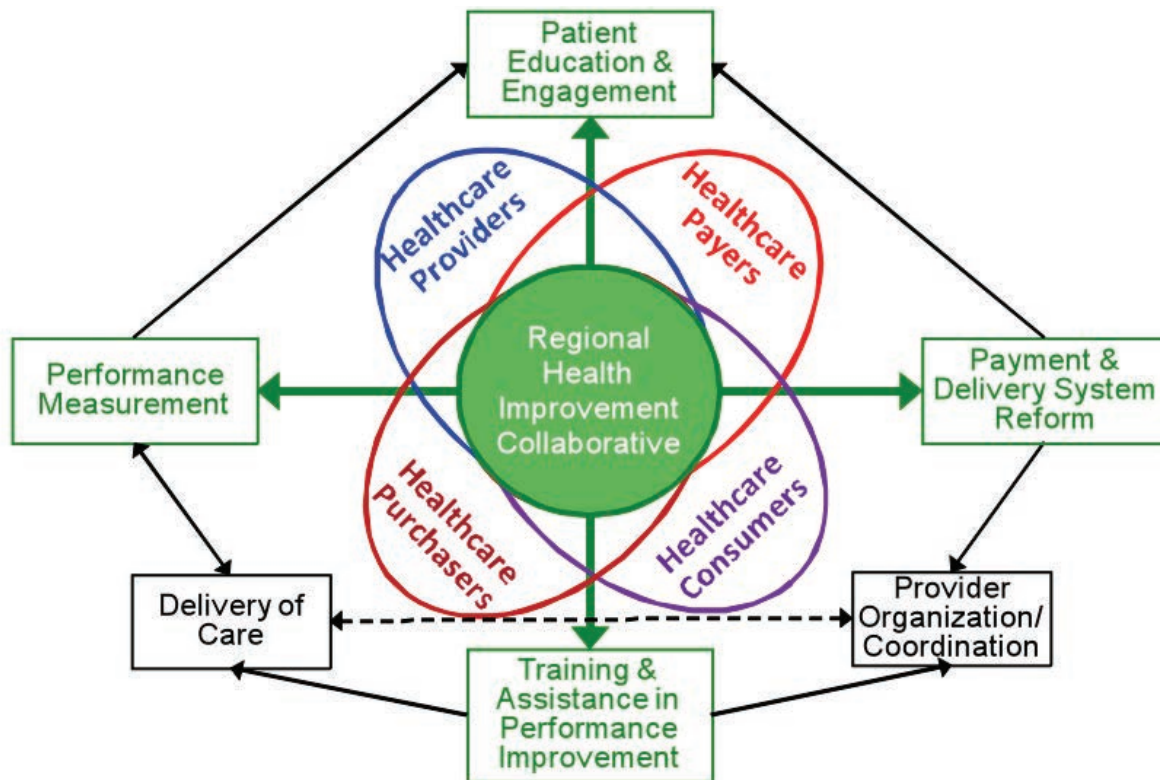
### **Quality of Physician Services**

Some Regional Health Improvement Collaboratives collect and publicly report data on the quality of care delivered by physician practices. The types of measures reported include both clinical processes of care (e.g., did all diabetic patients receive a test to measure their level of blood sugar?) and care outcomes (e.g., how many diabetic patients had well-controlled blood sugar levels?).

Value should always be defined around the customer...Value depends on results...and is measured by outcomes achieved...Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to outcomes achieved is dangerous...leading to false “savings” and potentially limiting effective care.

*What Is Value in Health Care?* Michael E. Porter, Ph.D.  
The New England Journal of Medicine; 363:2477-2481; December 23, 2010





### Quality of Hospital Services

A number of Regional Health Improvement Collaboratives also report on the quality of care delivered in the hospitals in their community. Here again, the measures range from processes (e.g., how quickly heart attack patients were treated) to outcomes (e.g., infection rates and mortality rates).

### Patient Experience of Care

In addition to clinical quality measures, Regional Health Improvement Collaboratives can also collect and report information on patients' experience with healthcare services. For example, since 2005, Massachusetts Health Quality Partners has been collecting and reporting results from its statewide Patient Experience Survey on patients' experiences with their primary care providers, making Massachusetts the first state in the nation to report about patient care experiences publicly, down to the physician practice site level.

### Cost of Healthcare Services

A number of Regional Health Improvement Collaboratives have also begun developing measures of the total cost of care including the prices charged for individual services, the extent to which the most cost-effective services are used, and the total number of services used to address a particular healthcare issue.

### Disparities in Quality

In addition to reporting on the quality of care for all patients, some Regional Health Improvement Collaboratives are also reporting whether there are differences in the quality of care for different types of patients. It is important to recognize that not only are Regional Health Improvement Collaboratives collecting and publicly

reporting an extensive array of quality measures, they are also actively using those measures to encourage improvements in the quality of health care in their communities. Indeed, in many cases, the measures have been developed specifically to support a local quality improvement initiative, rather than the other way around.

## **2. Payment and Delivery System Reform**

Although performance measurement efforts have made a positive impact on quality, only so much can be done when healthcare payment systems penalize improvement and the fragmentation of providers impedes coordination. Significant changes in the way health care is paid for, the way providers are organized, and the way consumer benefits are structured will be needed to achieve greater value in health care. Regional Health Improvement Collaboratives serve as a neutral planning and problem-solving forum where win-win-win multi-payer, multi-provider payment and delivery reforms can be designed.

In a number of cases, the performance measures collected and reported by Regional Health Improvement Collaboratives are being used by all employers and health plans in the community to reward providers that deliver higher-quality care and to encourage patients to use higher-quality providers. Using a common set of measures developed by the Regional Health Improvement Collaborative reduces administrative costs for both plans and providers.

Regional Health Improvement Collaboratives were among the first healthcare leaders in the country to recognize that more fundamental payment reforms were needed than pay-for-performance systems. In 2007 and 2008, the Network for Regional Healthcare Improvement convened two National Payment Reform Summits that brought together national thought leaders and regional stakeholders and made detailed recommendations on the types of reforms needed to payment systems and what was needed to implement these payment reforms successfully in regions across the country. Building on NRHI's national summits, a number of Regional Health Improvement Collaboratives have held regional Payment Reform Summits to build consensus in their communities on the types of payment reforms which should be implemented by all payers, so that physicians and other healthcare providers are not forced to deal with multiple, disparate new payment structures. Many Collaboratives are also working with all of the stakeholders in their communities to implement multi-payer payment reforms. Another National Payment Reform Summit will be held in 2016.

Finally, no matter how much effort is put into designing new payment systems and delivery system reforms, implementation problems will inevitably arise. A Regional Health Improvement Collaborative that is supported by all stakeholders and perceived by them as neutral can provide a critical mediation mechanism for resolving problems quickly and effectively.

## **3. Training and Assistance in Performance Improvement**

Although measurement and reporting and changes in payment systems and organizational structures are necessary to support higher-value healthcare delivery, improvements in quality, efficiency, and patient satisfaction are actually achieved through the actions of front-line healthcare workers. Regional Health Improvement Collaboratives operate programs which enable physicians, nurses, hospital administrators, and other healthcare professionals to obtain affordable training, coaching, and technical assistance on ways to analyze problems in care delivery and ways to design and successfully implement solutions.

#### **4. Patient Education and Engagement**

Even the best-performing healthcare providers can only do so much to improve quality and reduce costs without strong support and engagement from patients. Regional Health Improvement Collaboratives help citizens in their communities (a) understand and actively engage in activities that will maintain and improve their health, (b) choose providers and services based on their cost and quality, and (c) support the delivery of higher quality, more coordinated care.

#### **5. Strategic Planning and Coordination**

Finally, in addition to the previous four roles, an increasingly important role for Regional Health Improvement Collaboratives is to provide the critical planning, coordinating, and support roles that will ensure these many inter-related changes happen successfully and in a coordinated way. The structure of a Regional Health Improvement Collaborative is designed specifically to help build consensus among all healthcare stakeholders on the changes needed in their community, and then to provide support, coordination, monitoring as assessment during the implementation of those changes.

#### **The Structure of Regional Health Improvement Collaboratives**

To be successful, the roles described above need to be performed with the full support and trust of all of the key stakeholders in health care:

- healthcare providers, i.e., physicians, medical practices, hospitals, and health systems;
- healthcare payers, i.e., health insurance plans and public programs such as Medicaid;
- healthcare purchasers, e.g., employers or unions that purchase health insurance for workers;
- healthcare consumers and organizations representing consumer interests.

Regional Health Improvement Collaboratives engage all stakeholders in the governance of the Collaborative organization as well as in the design and operation of individual programs. Indeed, a key difference between Regional Health Improvement Collaboratives and organizations such as Medicare quality improvement organizations (QIN/QIOs), business health coalitions, regional health information exchanges, consumer health coalitions, medical societies, hospital associations, and others that work on quality improvement is that the Collaboratives are governed by individuals and organizations from all four of the key stakeholder groups. This is why Collaboratives are referred to as “multi-stakeholder” rather than merely “membership” organizations. Other differences between Regional Health Improvement Collaboratives and other organizations is that Collaboratives establish their direction through consensus among their members and implement their efforts through voluntary cooperation of the members, rather than through government mandates, financial rewards or penalties, etc.

Beyond this, however, no two Regional Health Improvement Collaboratives are structured exactly alike. Always neutral and nonpartisan, Collaboratives are still very diverse in terms of their goals, structure, and programs because of the differences in the number, structure, and capabilities of the purchasers, payers, providers, and other community organizations in their local regions. The following brief review of key NRHI members demonstrates this point.

# Network for Regional Healthcare Improvement (NRHI)



## History

Regional Health Improvement Collaboratives (RHICs) mobilize community resources to solve key problems where markets fail to promote the continuous creation of higher value through improved quality and access at lower cost. By working closely with providers, insurers, employers, unions, consumer groups, and government agencies, these coalitions achieve solutions that no market participant could achieve individually. The Network for Regional Healthcare Improvement (NRHI) was created to connect local RHICs and facilitate the exchange of best practices, contacts, and program access while articulating the needs of RHICs in national forums.

NRHI was founded in 2004 to share learnings in quality improvement and healthcare transformation among seven leading regional collaboratives: the California Cooperative Healthcare Reporting Initiative, California Quality Collaborative, Institute for Clinical Systems Improvement (ICSI), Massachusetts Health Quality Partners (MHQP), Minnesota Community Measurement (MNCM), Pittsburgh Regional Health Initiative (PRHI), and Wisconsin Collaborative for Healthcare Quality (WCHQ).

In 2007, NRHI was formally established with financial support from the Robert Wood Johnson Foundation, the California Health Care Foundation, and the Jewish Healthcare Foundation (PRHI's parent organization) with the goal of providing networking services to help regional health improvement collaboratives across the country more quickly identify, understand, and overcome barriers to growth and effectiveness. NRHI has approximately 35 members whose leaders also comprise its board. The members cover a wide geographic spread, with representatives from approximately half of the states in the U.S.

NRHI supports RHICs in accelerating local healthcare improvement, provides technical assistance to emerging coalitions, and informs the national policy agenda. NRHI's first projects included convening two national payment reform summits, which became a signature event focused on "roll your sleeves up" working sessions. These events laid out the barriers to transformation and identified local strategies to overcome those obstacles.

## Leadership

NRHI's first president and CEO, Maulik Joshi, was hired in 2007. Harold Miller was appointed CEO in 2008 and continued until 2013, when Elizabeth Mitchell assumed the role and helped grow the NRHI team from one employee – her – to approximately 20 full-time individuals. The current team includes Ellen Gagnon, Senior Project and Operations Director, and Dianne Hasselman, Deputy Director.



## Strategies

Solutions to the quality, access, and cost challenges in American health care must be implemented on a regional basis, since American health care is largely delivered in regional markets. The central problem is how to achieve national scale, speed, and efficiency to mobilize regional healthcare stakeholders, develop market-based solutions, and implement them to create value at the point of care.

NRHI addresses this problem by helping regions coordinate their efforts to transfer successes rapidly. This coordination leverages limited local resources to implement successful solutions more rapidly, avoid duplication of development work, and align performance and infrastructure standards.

## Services/Expertise

As the national organization of RHICs, NRHI is the connective tissue between its members and brings them together – virtually or in-person – through many learning and collaborative events. For example, NRHI provides the infrastructure and staff to:

- Host conversations across communities about cutting-edge issues like end-of-life care and reducing inappropriate utilization
- Convene a public policy committee to understand the national policy landscape and advance the role of RHICs
- Obtain grant funding to support and coordinate multi-RHIC national initiatives, such as understanding the variation of quality and cost across and within states, and calculating the total cost of care at the provider level
- Host leadership development events with the “rising stars” from within communities
- Ensure that federal and national leaders understand what RHICs are and the value of local, multi-stakeholder collaboratives



NRHI has set the stage for many of the important regional and statewide collaborations that drive the agenda of improving healthcare quality and costs. While this goal seems very obvious today, when the work began, there was little momentum behind this movement and a huge need for regional efforts to learn from one another. Karen Feinstein and the Pittsburgh Regional Health Initiative were a driving force to making it happen. NRHI has evolved to help set the national agenda and continue to support important local efforts. After all, health care is still local.

Sophia Chang, MD, MPH, Chief Clinical Innovation Officer for CareMore Health Plan; Former Director of Better Chronic Disease Care and VP of Programs at the California Health Care Foundation

Through connecting local RHICs to each other, NRHI accelerates the process for communities to learn about, test, and adopt strategies that create a higher-quality, cost-effective, and patient-centered healthcare system.

A unique aspect of NRHI's role is to help the federal government – particularly CMS – understand the available network of RHICs throughout the country, what they do collectively and individually, and why they are an ideal partner to engage providers, employers, patients and insurers in changing health care. CMS leadership recognizes that RHICs convene all regional stakeholders, explain the federal (or state) policy or initiative, and then, most importantly, develop a local implementation approach. Equally important, NRHI helps CMS understand how its policies are playing out locally – where there are questions, barriers, unrealistic expectations, and alternative approaches.

### **Networks/Partnerships**

Without NRHI, the speed with which transformative health and health care occurs throughout regions and states would diminish greatly. Multi-stakeholder collaboration and convening is complex and difficult work, and having a network of peers for encouragement and inspiration is a key ingredient for progress. NRHI has noteworthy partnerships with national associations including medical, quality, business, governmental, and others which have helped to spotlight the significance, at a national level, of the role and value of regional collaboration.

NRHI's network includes some RHICs which cover their entire state, and some that cover specific geographic regions. The RHICs vary in terms of size, with staffing ranging from a few individuals to more than 50. While their missions are aligned – to improve quality, reduce costs, and improve patient care – some in the networks are more provider-led, while others were created by employers and purchasers. Regardless of their origin, they are all multi-stakeholder and are recognized as an ideal mechanism in their communities for developing coordinated, multi-stakeholder solutions for their healthcare quality and cost problems.

### **Major Accomplishments**

By far, NRHI's brightest accomplishment is its vibrant and thriving network of approximately 35 RHICs covering almost half of the U.S. NRHI is the only network in the country with this membership, which continues to grow. NRHI's goal is to cover all geographies in the U.S., particularly in the southeast and frontier states.

Three multi-state initiatives are successfully exhibiting that RHICs are demonstrating the ability to forgo their own individual interests for the collective good – essentially, “walking the talk” about collaboration. These initiatives revolve around understanding and sharing information about the total cost of care, identifying and understanding quality and cost variation between and within states, and advancing transparency of meaningful and actionable cost and quality information. These initiatives are NRHI’s “proof of concept” that reveals that healthcare transformation can move faster and farther through collaboration and alignment.

In 2014, NRHI convened national thought leaders, healthcare measurement experts, and colleagues from across the country for a multi-day forum – the National Physician Leadership Seminar – to provide feedback on comparative healthcare cost reports and their usefulness in identifying cost variations and interventions. The seminar brought physicians together to learn about national movements and research related to understanding the total cost of care. The event, made possible through funding from the Robert Wood Johnson Foundation, was part of NRHI’s “Getting to Affordability” initiative.



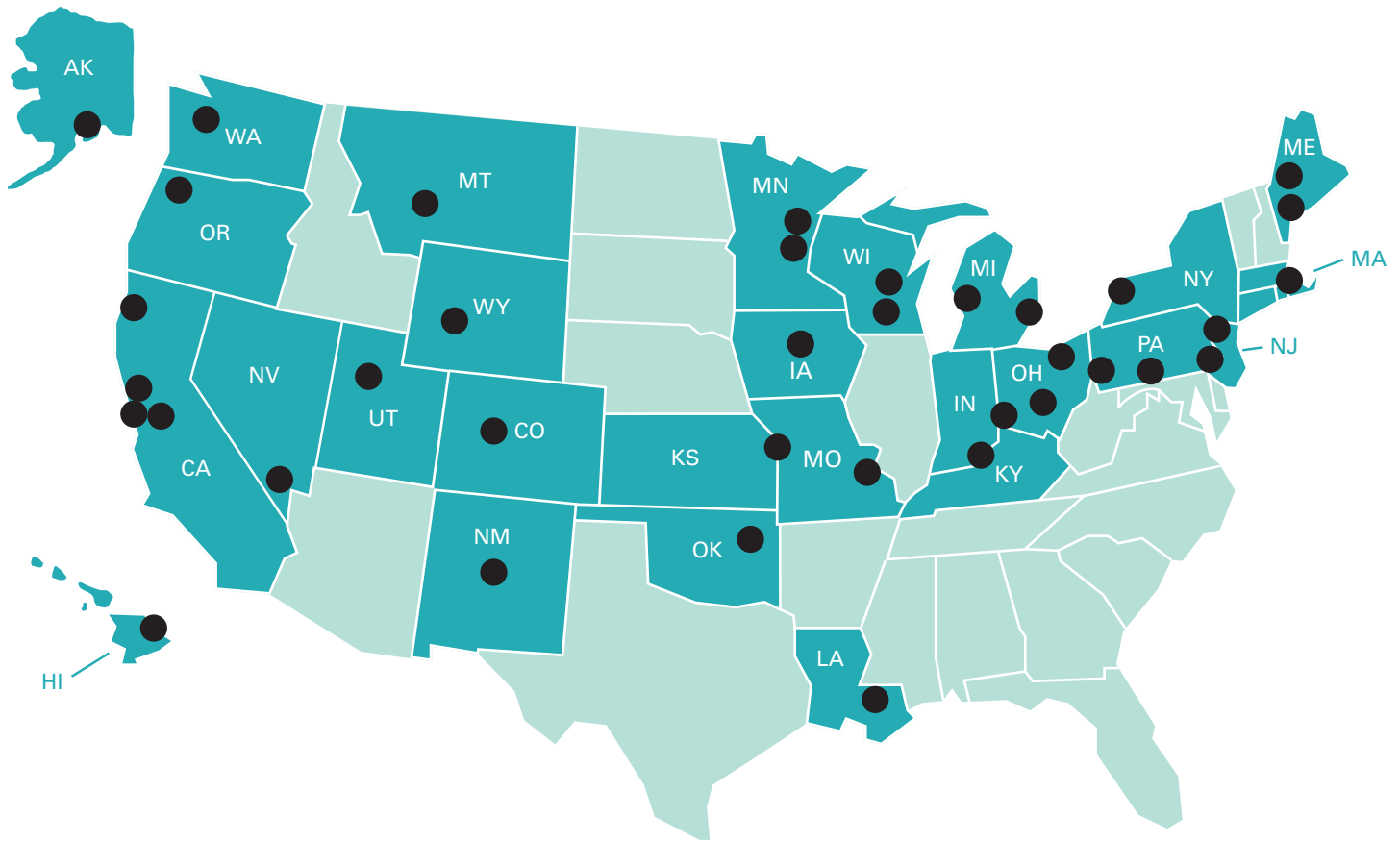
Elizabeth Mitchell

### **Why Join NRHI**

In the words of NRHI CEO Elizabeth Mitchell: “It’s so evident to me that our only hope in having a healthcare system that is efficient, effective and, above all, truly patient-centered means we need all stakeholders at the table, working together with humility and transparency, to figure out local solutions. When multi-stakeholder collaboration works, the community benefits. Regional collaboratives are the only vehicle to deliver on this audacious effort, and NRHI is the only place where RHICs come together.”

### **The Future**

NRHI will continue its efforts to scale the great work happening in communities every day that – taken together – could fix our healthcare system and reduce the cost burden on families. Recognizing that communities don’t have the luxury of waiting for policymakers or a national solution, NRHI’s network will accelerate adoption of what works, support the growth and sustainability of multi-stakeholder collaboratives, and promote leadership from all sectors.



Aligning Forces for Quality-South Central PA

Better Health Partnership (Ohio)

California Quality Collaborative

Center for Improving Value in Healthcare  
(Colorado)

Community First, Inc. (Hawaii)

Finger Lakes Health Systems Agency (New York)

Greater Detroit Area Health Council

Health Care Improvement Foundation  
(Pennsylvania)

Healthcare Collaborative of Greater Columbus

HealthInsight Nevada

HealthInsight New Mexico

HealthInsight Utah

Institute for Clinical Systems Improvement  
(Minnesota)

Integrated Healthcare Association (California)

Iowa Healthcare Collaborative

Kansas City Quality Improvement Consortium

Kentuckiana Health Collaborative

Louisiana Health Care Quality Forum

Maine Health Management Coalition

Maine Quality Counts

Massachusetts Health Quality Partners

Michigan Center for Clinical Systems  
Improvement

Midwest Health Initiative (Missouri)

MN Community Measurement (Minnesota)

Mountain-Pacific Quality Health Foundation  
(Alaska, Hawaii, Montana, Wyoming)

MyHealthAccess (Oklahoma)

New Jersey Health Care Quality Institute

North Coast Health Information Network  
(California)

Oregon Health Care Quality Corporation

Pacific Business Group on Health (California)

Pittsburgh Regional Health Initiative

The Health Collaborative (Ohio)

Washington Health Alliance

Wisconsin Collaborative for Healthcare Quality

Wisconsin Health Information Organization



# Collaboratives Speak for Themselves

Every Regional Health Improvement Collaborative (RHIC) is a story about stakeholders coming together to try to solve the twin dilemmas of the U.S. healthcare system—high cost and unreliable performance. The search for solutions has led some Collaboratives to focus on improving population health and reducing disparities. Others have developed innovative approaches to disease management, payment reform, waste and inefficiency, and patient safety. As unique as each Collaborative is, their common goals and aspirations and their similar analyses of what ails U.S. health care and how to fix it, bind them in vital networks.

# Region: East



# Aligning Forces for Quality – South Central PA (AF4Q SCPA)



## History

Aligning Forces for Quality South Central Pennsylvania (AF4Q SCPA) was founded in early 2007 with a mission to improve the quality of the care provided to patients in the region through collaborative learning, consumer engagement, and performance benchmarking. Initial funding for AF4Q SCPA came from participating in Robert Wood Johnson Foundation’s Aligning Forces for Quality project, which ran through 2015. AF4Q obtained subsequent operating support through a regional accountable care organization (for managing its ambulatory care transformation efforts) and a large integrated health system.

## Leadership

Christine Helwig Amy, MBA has been the Director for AF4Q SCPA since its founding. In addition, Kathy Hutcheson, MBA, MHA has the role of Consumer Engagement Coordinator; Samantha Obeck, RN, DNP is the Quality Improvement Coordinator; and Jenn Kuska is the Administrative Assistant. The multi-stakeholder steering committee is comprised of six healthcare providers, three health plans, and three community and consumer representatives.

## Strategies

For more than five years, AF4Q SCPA published online public reports on quality measures for ambulatory and inpatient care. The results highlighted the need for regional healthcare quality improvement and allowed providers to actively benchmark.

AF4Q SCPA is invested in two key strategies to achieve its mission of improved quality of care:

1. Learning collaboratives that engage more than 65 provider practices or provider entities in best practice improvement strategies, and
2. The Patient Partner Program which embeds patient advisors into foundational improvement work, both at the micro practice and macro community and health system levels.

Helping patients to make better decisions in their own health and with their health care is a key tenant of AF4Q SCPA. Through both the Patient Partner Program and various other programs like the “I Can! Challenge” and “It’s Your Health...Take Charge,” AF4Q SCPA helps empower patients about their health and become positive change agents for the healthcare system. The Patient Partners, a group of 80 individuals (as of early 2016), have shown that their commitment to creating a better health system can create a healthier community. These patients have been trained and supported to engage with the

health system as patient advisors in quality improvement work. Research has shown that these patients were more activated in their own care through their involvement in quality improvement activities with their healthcare provider, and that they positively influenced other community members.

### **Services/Expertise**

AF4Q SCPA has been a longtime change agent in Pennsylvania's numerous chronic disease healthcare initiatives over the course of three different governors, serving in key advisory and implementation roles. Reputable organizations seek to work with AF4Q SCPA, including the Pennsylvania Department of Health and Medicaid managed care organizations. In addition, the Centers for Medicare and Medicaid Services has interviewed AF4Q SCPA on numerous occasions about their successful work with patient-centered medical home collaboratives and their Patient Partner Program.

AF4Q SCPA provides services that include:

- Building quality improvement collaboratives for healthcare providers and payers, and providing consultations to improve existing collaboratives
- Working with providers and communities to bring the patient perspective into quality improvement initiatives
- Providing education about new models of care to primary and specialty care providers and their staff through Medical Home, Medical Neighborhood, and super-utilizer collaboratives. In addition, an annual nursing summit helps nurses expand their roles and responsibilities in today's healthcare environment

### **Networks/Partnerships**

AF4Q SCPA serves a key role in bringing competitors to the table with one goal in mind – better patient care. AF4Q SCPA pioneered a process for representatives from all facets of health care (providers, payers, consumers) to work together towards the higher purpose of greater healthcare quality in the region.

AF4Q SCPA's strategic partners include the Health Care Improvement Foundation, PA Spread, local accountable care organizations, numerous commercial payers, the nine healthcare provider systems in a four-county region, Pennsylvania Department of Health, state Medicaid providers, and CMS.

### **Major Accomplishments**

Payment reform, new models of care, and education are among the major accomplishments for AF4Q SCPA throughout its nearly decade-long history:

- In 2010 and 2011, AF4Q SCPA convened regional providers and employers to find a middle ground for payment reform adoption within the region. Through these events, two efforts resulted in pilot studies: bundled payments for hips, knees, and CABG (coronary artery bypass grafting) procedures, and patient-centered medical home. The region currently has significant levels of adoption of these two new payment models. More than 80 primary and specialty practices have become high-performing medical home and neighborhood members during the last five years.
- For the last three years, AF4Q SCPA partners have been at the forefront of testing new models of care related to super-utilizers – patients that use emergency and inpatient care at much higher levels than the norm, and on average have much higher socio-economic needs. Annual convenings with state officials and payers have helped



Pennsylvania understand the needs of these patients and the providers who care for them. In addition, five providers who care for super-utilizing patients developed a white paper that has been championed as a one-stop resource for others to develop their own programs.

- AF4Q SCPA has sponsored a Nursing Summit over the past three years which brought nursing representatives from more than nine competitors together to learn new skills and increase nursing leadership. Other AF4Q SCPA education efforts include the annual Summer Read, which is a one-book program that targets a health-related book such as *The Healing of America*, *Being Mortal*, and *Overwhelmed*. Libraries across a seven-county area engage in the program along with the local PBS television station. Book discussions, speaking events, and television and radio specials help the community to engage in issues related to healthcare cost, new models of care, unhealthy behaviors, stress management, and dying. The topic for an upcoming event revolves around mental health.

### **Why Join NRHI**

There are many nationally-based quality improvement organizations, but NRHI is much more than that. NRHI's role isn't to sell a seat at a conference, or publish a newsletter, or offer consulting services. NRHI is a common table for RHICs, a safe place to share, collaborate, and learn. AF4Q SCPA's wish is for NRHI to never move away from this important role of supporting the common needs of RHICs who do the work at the regional level. There is no other place that AF4Q SCPA can go to exchange ideas with other like-minded organizations, such as RHICs, except NRHI.

### **The Future**

AF4Q SCPA will continue to be a grassroots organization that works closely with providers, patients, payers, and state organizations to accelerate improvement through initiatives that bring healthcare providers together with healthcare recipients, fostering innovative thinking on how work can be accomplished.

## Finger Lakes Health Systems Agency (FLHSA)



### History

In 1961, Kodak Vice President Marion Folsom organized a health planning council of community leaders including consumers, hospital administrators, businesses, physicians, and government officials in Rochester, NY. A decade later, Finger Lakes Health Systems Agency (FLHSA) formally emerged after the passage of the 1974 National Health Planning and Resources Development Act, which granted federal authority and funds for state and regional health planning from 1975 to 1986. Today, the agency is a nonprofit 501(c)(3) organization. Since its early days, FLHSA has served as a community convener for healthcare planning. FLHSA focuses on community health issues by analyzing data, engaging the community, and implementing solutions.

### Leadership

FLHSA leadership in recent decades has included Bonnie Devinney, now chief operating officer of Rochester's United Way, and Fran Weisberg, now chief executive officer of the United Way. Today, the agency's chief executive officer is Trilby de Jung, JD, a former senior health law attorney at Empire Justice Center and former faculty member at New York University School of Law. Her expertise includes coalition building, management, and healthcare policy analysis and advocacy.

The FLHSA board of directors includes leaders from hospitals, insurers, businesses, human service agencies, education, and government. Agency leadership and staff include health data experts, physicians, and community advocates with extensive experience in their fields.

### Strategies

FLHSA focuses on three strategies to advance its mission:

- **Data** – The most complete source of healthcare data in the region is maintained by FLHSA, which also provides the expertise in population-based analytics to deliver a community-wide overview of current health status and challenges.
- **Collaboration** – FLHSA gathers hospital systems, health insurers, county health departments, physician groups, consumers, and other partners to review data and design community-wide action plans.
- **Transformative interventions** – FLHSA manages health initiatives, including the anti-obesity campaign "Healthi Kids," the "High Blood Pressure Collaborative," and a practice transformation initiative aimed at helping clinicians transition to patient-centered, data-driven care.

### Services/Expertise

Data, collaboration, and transformative interventions are not merely strategies – they are FLHSA's specialties.

- **Data** – FLHSA assists local health departments and hospitals with developing county health activities. FLHSA also supplies data to inform health improvement assessments and hospital community service plans in a nine-county region. In 2015, it provided the Finger Lakes Performing Provider System with a community needs assessment for the Medicaid population.

- Collaboration – In 2016, FLHSA will convene the Alzheimer’s Disease Regional Plan for the University of Rochester, the local Alzheimer’s Association, and other local groups.
- Transformative interventions – FLHSA’s practice transformation initiative holds regular learning collaboratives for care managers and champions at 65 participating practices, sharing best practices around team-based, data-driven primary care. They also host graduate and undergraduate students, allowing them to experience first-hand how collaboration works and contribute to FLHSA’s efforts.

**Networks/Partnerships**

Through FLHSA, the Finger Lakes region receives community-wide data and has an independent venue for competing hospital systems, insurers, and other healthcare stakeholders to collaborate. With data and staff support from FLHSA for Community Technology Assessment Advisory Board (CTAAB) and Certificate of Need (CON) reviews, the Finger Lakes region collectively evaluates redundant or low-value healthcare expansions. CTAAB and CON reviews have played an important role in keeping healthcare costs low in the region, while maintaining quality and access. During fiscal 2015-2016, for example, CTAAB reviewed five projects representing more than \$47 million in capital costs, and \$11 million in incremental annual community costs. Those reviews saved the region \$2.9 million in capital costs.

FLHSA partners with more than 100 organizations on planning activities, including city, county, and state government, as well as the two area hospital systems, other healthcare groups like nursing homes and federally qualified health centers, major employers, and academic institutions. Partnerships include patient surveys with Massachusetts Health Quality Partners, business relationship strategies with Maine Health, payment ideas with west coast organizations such as Integrated Healthcare Association, community engagement with Washington Health Alliance, and sharing with the P2 Collaborative. FLHSA’s program initiatives also engage more than 100 partners, including schools, clinical practices, congregations, barbershops and salons, businesses, and insurers.

**Major Accomplishments**

FLHSA’s ability to bring together regional stakeholders has led to successful bids for CMMI dollars to support clinical initiatives, such as a \$26.6 million practice regional transformation grant in 2012 and a \$48.5 million statewide grant in 2015. These efforts are improving patient outcomes and bending the cost curve. The following is a description of some of FLHSA’s successful initiatives:

- Over the five-year “High Blood Pressure Collaborative,” the registry documented a 13.7 percent improvement in high blood pressure control.
- The “Regional Commission on Community Health Improvement,” which ran from 2014-2015, provided an action plan for preventing chronic disease, improving



Regional Commission on Community Health Improvement

senior care, and integrating behavioral health with other medical care in the Finger Lakes region. The commission and its workgroups drew on the expertise of 150 regional leaders from public health, human services, health care, community-based organizations, and other health-related fields.

- The ongoing African American and Latino health coalitions and “Partnership on the Uninsured” provide feedback and develop strategies for addressing health disparities. These committees include leaders from community health organizations, government, nonprofits, and related organizations.
- The “Healthi Kids” initiative advocates for physical activity, more nutritious lunches in city schools, and encourages walking to school. The program successfully advocated for a complete streets policy in Rochester that requires planners to accommodate walkers and bicyclists.

FLHSA’s CMMI-funded work over the past three years has paid for an embedded care manager who works one-on-one with patients in 65 practices. The project also provides training in team-based care to help providers become more patient centered. FLHSA’s high blood pressure initiative provides funding for frontline advocates who coach patients, and physician consultants who work directly with staff to share evidence-based approaches.

As *The New York Times* recently reported, the Rochester region boasts some of the country’s lowest Medicare and commercial healthcare costs while maintaining high quality and access to care. FLHSA’s long history of facilitating regional cooperation around health care and the region’s support for CTAAB are important contributors to that success.

In recognition of the agency’s ability to provide bigger picture insights, FLHSA was asked to serve on multiple planning tables this year including the Rochester Monroe Anti-Poverty Initiative, the Finger Lakes Performing Provider System, the Regional Economic Development Council, and statewide workgroups convened by the New York State Department of Health on value-based payment, integrated care, and workforce. When the DOH wanted to support regional health planning statewide, it tapped FLHSA to provide technical assistance to the ten other newly-designated Population Health Improvement Program organizations.

### **Why Join NRHI**

FLHSA joined NRHI as a partner in a Robert Wood Johnson Foundation’s Rewarding Results grant that brought together other regional initiatives. Membership in NRHI allows the agency to tap into the wide variety of approaches embraced by groups committed to local action on health care and health. FLHSA benefits from shared thinking, strategy, and lessons learned by other not-for-profit regional organizations dedicated to improving health through reporting, measurement, and community projects.

### **The Future**

In 2016, the Regional Consortium on Health Care Workforce and its three workgroups will identify the new skills and educational opportunities needed to meet the region’s healthcare workforce requirements over the next decade. The consortium brings together top-tier leadership from educational institutions, hospital systems and other healthcare employers, health insurers, and business, as well as representative healthcare consumers.



# Health Care Improvement Foundation (HCIF)



## History

The Health Care Improvement Foundation (HCIF) was founded in 1980 as the education and research arm of the Delaware Valley Healthcare Council, but has operated since 2003 as an independent 501(c)(3) organization. This reorganization was a result of HCIF leaders recognizing the potential for a broader quality improvement role beyond the hospital setting.

HCIF drives high-value health care through stakeholder collaboration and targeted quality improvement initiatives. HCIF's signature initiative, the "Partnership for Patient Care," began in 2006 with funding from Independence Blue Cross and hospitals in southeastern Pennsylvania. Guided by a clinical advisory committee of local safety leaders, "Partnership for Patient Care" aimed to accelerate the adoption of evidence-based clinical practices to promote patient safety. The majority of acute care hospitals in southeastern PA have taken advantage of the 23 initiatives offered during the first decade of "Partnership for Patient Care."

## Leadership

HCIF President Kate Flynn joined the organization in 2008 as the first independent staff member. Other senior staff members include Pam Braun, RN; Susan Choi, PhD; and Erik Muther. HCIF maintains a staff of ten professionals with a wide range of experience in quality improvement, clinical practice, hospital management, patient safety, public health, health literacy, and performance measurement. The diversity of the HCIF board – featuring 21 leaders representing health systems, health payers, the business community, the public health sector, and consumers – has assured its reputation as a neutral convener.

## Strategies

In each of HCIF's programs, organizations voluntarily come together to adopt a common goal and commit to shared expectations, including forming an improvement team and supporting an executive champion. The teams are provided a venue and structure to take accountability for performance, share challenges as well as successful practices, and most importantly, create a community in which participants support one another in implementing meaningful change.

## Services/Expertise

HCIF's work falls into three broad areas of expertise:

- Clinical and patient safety improvement
- Community and population health improvement
- Public reporting and data transparency

In addition to convening and managing collaborative projects, HCIF sponsors an annual award program, conducts an annual patient safety symposium, provides education and training, and maintains a public website offering comparative data on provider quality in PA.

### **Networks/Partnerships**

HCIF's base in the five-county Philadelphia metropolitan area is home to some of the most impoverished, unhealthy neighborhoods in the country, as well as several of the nation's most highly-regarded academic medical centers. HCIF leads efforts to successfully connect the provider community with the public health sector to achieve better alignment and collaboration. HCIF has earned growing recognition for its ability to engage multiple stakeholders in significant health initiatives, and has recently been called upon to develop similar opportunities in central PA.

Every HCIF initiative involves multiple partners, but some significant relationships include the Pennsylvania Department of Health, Independence and Capital Blue Cross plans, Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Patient Safety Authority, ECRI Institute, the Institute for Safe Medication Practices, the Philadelphia Department of Public Health, and numerous health systems and universities in Pennsylvania. In addition, HCIF's recent merger with the Pennsylvania Health Care Quality Alliance brought with it a close relationship with Aligning Forces for Quality in York, PA.

### **Major Accomplishments**

In 2009, HCIF undertook a multi-year effort based on collaboration and shared funding to adopt a high-reliability approach to patient safety. Among 17 participating hospitals, the aggregate serious safety event rate has dropped more than 40% from baseline, resulting in a decrease of more than 100 instances of serious patient harm each year. HCIF is now planning a "Safe Table" for protected disclosures of serious events. Experts have noted that no other geographic region of the country has collaborated to achieve such a widespread transformation of safety behavior.

HCIF was also a founder and incubator of HealthShare Exchange of southeastern PA, the region's first health information exchange. Although previous efforts to create a regional health information exchange had failed, HCIF successfully convened payers and providers in 2011 to jointly commit to a nonprofit "community asset" instead of creating competing proprietary systems that would require costly, redundant connectivity. HCIF led successful efforts to secure start-up funding support and was the original incorporator of the new organization.

Collaborative efforts expand beyond high-level healthcare professionals. HCIF encourages the inclusion of frontline workers and patients as members of improvement teams. As an example, the PAVE care transitions project conducted from 2010-2013 included extensive teach-back training, patient feedback, and unit-based pilot projects as part of a regional strategy that resulted in a 10% improvement in readmission rates. Through its health literacy initiatives, HCIF educates frontline staff and also trains peer educators at community-based organizations to help consumers improve their interactions with healthcare providers.

Many of HCIF's initiatives include developing new patient-focused tools and materials. HCIF's palliative care initiatives in southeastern and central PA have led to improvements in the frequency and quality of end-of-life conversations. HCIF's leadership of the obstetrics immersion project within the Hospital Engagement Network has achieved a marked reduction in early elective deliveries (significantly lower than the national average), with a concerted effort to raise patient awareness of the risk of early delivery to newborns. HCIF's health literacy efforts focus on equipping patients with tools such

as Ask Me 3<sup>®</sup> to improve their understanding and decision-making, as well as assisting hospitals in creating health-literate materials. HCIF also provides online resources to patients and the public, including data on hospitals and cancer centers, as well as a statewide directory of patient-centered medical homes in Pennsylvania.

### **Why Join NRHI**

One of HCIF's core values is that collaboration is the key to effective and sustained improvement. HCIF joined NRHI to “walk the talk” – to share their experiences with like-minded organizations across the country, and apply best practices and lessons learned from others to accelerate their own work.

### **The Future**

HCIF plans to collaborate with others to develop a statewide resource for transparent quality and cost information. Healthcare costs and utilization in PA – particularly in the southeast – are considerably higher than the rest of the country, with only average performance on patient outcomes. Through its merger with the Pennsylvania Health Care Quality Alliance, HCIF affirmed its commitment to advancing transparency to improve provider accountability, as well as purchaser and consumer value.

## Maine Health Management Coalition (MHMC)



### History

“Are we getting value for our healthcare spend?” That basic but important question was the catalyst that led insurance broker John Benoit to form the Maine Health Management Coalition (MHMC) in 1993 as an attempt to understand and address variance in healthcare costs. Benoit and several large employers believed that they could pool claims data to get a clearer picture of why their insurance rates continued to climb. After assembling a comparative database of claims information, however, they found that it was impossible to fully understand the variances they were seeing without first having access to data on the effectiveness of health services. That realization led to a fruitful dialogue between clinicians and employers – and the establishment of MHMC.

MHMC is a purchaser-led, multi-stakeholder membership organization, with a 13-person board of directors consisting of purchaser, provider, health plan, and consumer representatives. The stakeholders work collaboratively to improve health and to maximize the value of healthcare services for all residents of Maine.

MHMC began to develop and publicly report performance measures as a means of rating the quality of health care delivered to the people of Maine. With input from all stakeholders, an equitable method of judging clinical effectiveness began to take shape. The group agreed to start with measuring adherence to evidence-based guidelines, then progressed to reporting outcome measures, and ultimately moved on to reporting cost measures. Today, every hospital in Maine and nearly two-thirds of primary care physicians voluntarily report data for publication on MHMC’s public-facing website, [www.getbettermaine.org](http://www.getbettermaine.org).

The earliest projects at MHMC centered on using its rich claims database to identify and report healthcare trends and variations in member utilization. MHMC’s research quickly expanded, however, to include process and structure measures to inform members of providers who have the systems in place to deliver safe, effective care. MHMC’s primary funding sources are membership dues, data analytics, and grants.

### Leadership

MHMC was initially led by Doug Libby, a hospital pharmacist, who helped to make sense of health plan data, formalized the organization, and built its membership. He also established the organization’s first public reporting efforts. The transparency efforts are used by providers to improve quality, by consumers to make informed choices, and by purchasers to incentivize employees to seek high-value care.

When Libby retired in 2008, Elizabeth Mitchell took over as CEO. Mitchell sought grant funding to grow the organization and hired Nancy Morris as a Communications Director and Michael DeLorenzo as the Data Analytics Director. Together, the trio began to rapidly expand MHMC’s funding base and operations.

Current staff leaders include Andrew Webber, MHMC’s President and CEO; Peter Flotten, Director of Operations; Tim Hannan, Director of Data Systems and Analytics; Lorrie Marquis, Director of Measurement and Transparency; Frank Johnson, Director of System and Payment Reform; and Eve Preston, Grants Development Director.

## **Strategies**

MHMC uses four key strategies to advance its mission: transparency and public reporting, member and consumer engagement, value-based insurance design, and payment reform. Each of these strategies is underpinned by a robust data analytics program that helps employers and providers make informed decisions about the way they pay for and deliver care.

## **Services/Expertise**

MHMC offers a range of services aimed at helping its members to be smarter healthcare consumers and providers. Its key offerings include:

- Provider analytics, which help providers identify high-risk patients, out-of-network utilization, quality gaps, and quality performance variance
- Employer analytics, which help purchasers to identify cost drivers, savings opportunities, and statewide benchmarks
- Public reporting of quality and cost information for hospitals, primary care, pediatrics, behavioral health, and medical specialty practices on MHMC's consumer website, where patients are able to see how their provider compares on a range of metrics like safety, efficacy, and patient experience
- In-person and online educational sessions, such as conferences and webinars on topics ranging from quality improvement to value-based insurance design

MHMC's most vital service, however, is its role as a trusted, multi-stakeholder convener. MHMC facilitates discussions on sensitive issues such as transparency, payment reform, cost containment, and value-based benefit design.

## **Networks/Partnerships**

Involved in numerous state and national networks with other health advancement organizations, MHMC is a State Innovation Model (SIM) partner, a Medicare Qualified Entity, and an Agency for Healthcare Research and Quality Chartered Value Exchange. MHMC is also a member of the National Quality Forum, The Leapfrog Group, the National Business Coalition on Health, and Aligning Forces for Quality, and works closely with national rating organizations like Bridges to Excellence and the National Committee for Quality Assurance.

MHMC has played a crucial role in numerous conversations and collaborations that have resulted in improved health care. MHMC helped Maine to achieve 100% participation among hospitals in The Leapfrog Group's hospital reporting initiative. Employers are tiering benefits on provider performance, and providers are participating in numerous reporting efforts. However, MHMC's impact is not confined to Maine's borders, as the organization is engaged in two key partnerships with other RHICs. The first is the Total Cost of Care (TCOC) initiative that is being coordinated by NRHI. The second partnership involves ten collaboratives in the DOCTOR Project, which is funded by RWJF and is being managed by Minnesota Community Measurement.

MHMC staff is sought after by many organizations. Andy Webber serves on the board of Families USA, the Patient-Centered Primary Care Collaborative, HCI3, and Maine Quality Counts, and is a member of the Institute of Medicine Roundtable on Population Health Improvement. Frank Johnson is on the Board of The Leapfrog Group and the Maine Health



Access Foundation. Susan Schow, a healthcare measurement analyst, is a member of the National Quality Forum's Consensus Standards Approval Committee (CSAC), while Lorrie Marquis is a member of the Daniel Hanley Center's Health Equity Advisory Committee.

### **Major Accomplishments**

One of MHMC's most significant accomplishments to date is the public reporting of TCOC for primary care practices in Maine. MHMC was able to garner multi-stakeholder support for TCOC, and was among the first places in the country to begin publicly reporting results.

In addition to the TCOC initiative, MHMC has also pioneered public reporting of behavioral health and specialty medicine. MHMC recently published ratings for mental health and substance abuse providers, as well as orthopedics/sports medicine, gynecology, obstetrics, and oncology and hematology. Outcome ratings in these areas are introductory, but consumers are now able to compare a whole new range of providers in the areas of efficacy, safety, and patient experience. Making this information transparent not only helps patients to choose the highest-performing practices, but also encourages lower-performing practices to improve by bringing their results to light.

MHMC has strived to advance alternative payment models in Maine, recently achieving multi-stakeholder agreement for a voluntary annual growth cap on risk-based contracts as well as a core measure set for assessing risk-based contracts.

### **Why Join NRHI**

MHMC joined NRHI since meaningful health care improvement starts from the ground up, and it is important to know what other RHICs around the country are doing to drive change. MHMC identified the tremendous value in learning about specific initiatives that others have taken to improve quality and lower cost, which may be replicable in the Maine market. Demonstrating success in other areas helps stakeholders to buy in to new, and potentially uncomfortable, changes.

In addition to the learning component, NRHI's communication around funding opportunities is very valuable, especially since MHMC's business model is heavily reliant on grants.

MHMC is looking forward to learning about more case studies of successful programs and initiatives elsewhere in the country, and is eager to communicate the value they deliver to their members and funders.

### **The Future**

MHMC will continue pursuing transparency and alignment in the healthcare system, and fostering a constructive dialogue among multiple stakeholders to improve the value of health care.

# Massachusetts Health Quality Partners (MHQP)



## History

Massachusetts Health Quality Partners (MHQP) formed in 1995 in response to an investigative story in *The Boston Globe* that rated hospitals based on mortality data. The late H. Richard Nesson, MD, then president of Brigham and Women's Hospital and chair of the Massachusetts Hospital Association's Board of Trustees, believed that the medical community would be in the best position to drive quality improvement and enhance patient outcomes by developing and reporting comparable, evidence-based performance data that would be shared with the public.

Nesson gathered a group of healthcare leaders (including Blue Cross and Blue Shield of Massachusetts – BCBSMA, Commonwealth of Massachusetts Executive Office of Administration and Finance, Fallon Community Health Plan, Harvard Pilgrim Health Care, Massachusetts Business Roundtable, Massachusetts Hospital Association, Massachusetts Medical Society, and Tufts Health Plan) to advance this goal. Together, these pioneers launched a statewide quality measurement and accountability initiative that became MHQP, long before transparency became a front-burner issue in health care.

MHQP's mission is to drive measurable improvements in healthcare quality, patient experience, and use of resources through patient engagement and broad-based collaboration among healthcare stakeholders. From its earliest years, MHQP worked with stakeholders to establish a common data set and standard format for reporting hospital quality to health plans. MHQP's flagship initiative was a statewide survey of patient experiences with acute care hospitals, a first-in-the-nation report that was publicly released in 1998.

In the early 2000s, MHQP switched its focus from hospitals to physician organizations. After securing a grant from The Commonwealth Fund and the Robert Wood Johnson Foundation, MHQP piloted a study of patients' experiences with primary care physicians, which became the precursor to the clinical group CAHPs survey instrument.

MHQP is governed by an active board comprised of diverse stakeholders that include representatives of health plans, healthcare providers, business leaders, academics, and patients. In addition, MHQP has an active health plan council, physician council, and a consumer health council, as well as ad hoc workgroups convened to offer guidance and tackle complex and emerging issues. As the health system has evolved these past two decades, MHQP has remained a trusted source for performance information.

## Leadership

MHQP's founding members include current Massachusetts Governor Charles Baker; Andrew Dreyfus, President and CEO of BCBSMA; Harris Berman, MD, Dean of the Tufts School of Medicine; Robert Galvin, who was the Executive Director of Health Services and Chief Medical Officer at GE International; and Founding Chair Joseph Newhouse, who now is the John D. MacArthur Professor of Health Policy and Management at Harvard University.

MHQP's founding Executive Director was Gina Rogers, who served in that role from 1996-1998. Barbra Rabson has been the President and CEO of MHQP since 1998. Under Rabson's leadership, MHQP has become a trusted source of physician performance information in Massachusetts, and MHQP is nationally recognized for its collaborative approach to collecting and reporting performance information to improve care.

### Strategies

MHQP is committed to a change model that drives transformation within the healthcare system with a dual approach that engages both healthcare clinicians and leaders, as well as patients and their families. MHQP believes that quality and affordability goals are achievable only if the patient's voice figures prominently into care improvements. Therefore, MHQP prioritizes the following strategies:

- Driving improvements in patient and family-centered care
- Measuring and reporting initiatives that are innovative and provide value
- Leveraging MHQP's multi-stakeholder governance and other assets to become an important partner with the state and others
- Uniting stakeholders, often with disparate agendas, to produce trusted, comparable performance measures that help drive healthcare quality improvement

### Services/Expertise

As a well-established consultant and convener for complex, multi-stakeholder issues, MHQP works to create collective, systematic change in the name of better health, better care, and lower costs for the community.



MHQP Board Chairs at the 15th Anniversary

MHQP is the only independent organization in Massachusetts that collects and publicly reports information about patients' experiences and clinical quality of care with their primary care providers for over 500 practices. MHQP created a website, Healthcare Compass MA ([www.healthcarecompassma.org](http://www.healthcarecompassma.org)), to help all Massachusetts residents learn about healthcare quality, make educated choices about where to seek care, and help them work with their doctors and other providers to receive high-value care.

In an effort to better reach consumers with reliable performance information, MHQP has published patient experiences of care and clinical quality results in Consumer Reports. MHQP was the first regional healthcare collaborative to publish with Consumer Reports in 2012.

The expertise of the MHQP staff is recognized and sought after. Barbra Rabson is a member of the State Auditor's Chapter 224 Advisory Committee, which was established to bring healthcare spending growth in line with growth in the state's overall economy. Another MHQP staff member is part of the MA All Payers Claims Database Data (APCD) Release Committee, which advises the Center for Health Information and Analysis on best practices regarding data release, security, and protection.

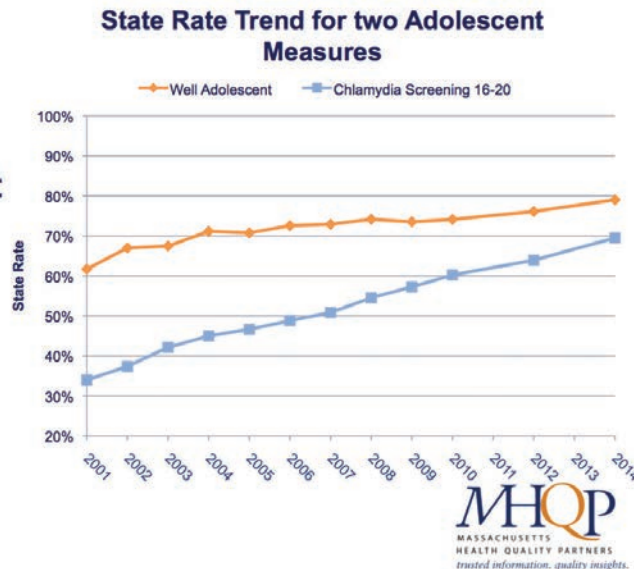
### Networks/Partnerships

MHQP is well integrated into the fabric of quality improvement within Massachusetts and nationally. MHQP is closely connected with the Massachusetts Medical Society, which has a seat on MHQP's board of directors, as well as with the Massachusetts Association of Health Plans (MAHP) and the Massachusetts Hospital Association (MHA). MHQP helped forge consensus among MAHP and MHA on an expanded set of quality measures, providing value to health plans, hospitals, and consumers.

## Adolescent Preventive Care

Well Adolescent (ages 12-21) state rate improved significantly PY2012 – PY 2014: 76% to 79%

Chlamydia (ages 16-20) state rate also improved significantly: 64% to 69.5%.



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MHQP also works with the Commonwealth of Massachusetts, including the state agencies that provide or monitor health care in Massachusetts, including MassHealth (Medicaid), Massachusetts Department of Public Health, the Executive Office of Health and Human Services, the Center for Health Information and Analysis, and the Attorney General's Office. A MassHealth representative sits on MHQP's Health Plan Council.

### Major Accomplishments

MHQP is the trusted leader in Massachusetts for objective, independent healthcare quality measurement and reporting. The organization is a leader in piloting and publishing data, with the consensus and support of health plans, provider organizations, patients, and other stakeholders. Some of the MHQP's achievements include:

- Creating in 1998 the first publicly-reported, statewide survey of patient experiences with acute care hospitals, which demonstrated the importance of patient experience for Massachusetts leaders, and also compelled national leaders to adopt patient experience as a legitimate quality measure
- Establishing in 2001 the first collaboratively produced, statewide adult and pediatric preventive care guidelines
- Playing a pivotal role in streamlining the reporting and measurement of primary care clinical performance and performance on patient experience in Massachusetts. Prior to MHQP, every health plan had its separate performance reporting measurement.
- Securing more than \$10 million in grant funding to support care delivery improvement in Massachusetts
- Creating in 2005 the first statewide reports comparing the performance of physician organizations based on a common set of quality metrics

- Developing in 2006 a first-in-the-nation statewide survey and public report of patient experiences with primary care clinicians. The survey, developed by MHQP and Dana Gelb Safran, became the precursor to the C-G CAHPS survey.
- Conducting in 2014 the first statewide Practice Pattern Variation Analysis to identify drivers of variation and low-value, high-cost care for 40 conditions
- Piloting in 2015 the first national test of a short-form electronic patient experience survey that includes patient comments

MHQP has earned the trust of the physician community and is well positioned to work with physicians to improve their performance. MHQP has collaborated with physician organizations to ensure that the data reported and the benchmarks used to demonstrate performance are accurate and reliable, while still meaningful to consumers.

### **Why Join NRHI**

MHQP played a key role in the founding of NRHI more than a decade ago, seeking out other regional health improvement collaboratives for support and to share best practices. As NRHI has grown, gaining national prominence and adding membership over the last 10 years, it is an important voice for MHQP and other RHICs across the country to bring regional healthcare improvement issues to the national policy agenda.

*“As one of the founding members of NRHI, it has been especially meaningful and rewarding to watch NRHI grow in size and influence over the past decade as it supported and connected a growing number of regional health improvement collaboratives. NRHI’s national leadership role on behalf of its members advances the important work that all of our communities do to drive measurable improvements in patient care, health, and value.”*

Barbra Rabson, President and CEO, Massachusetts Health Quality Partners

### **The Future**

MHQP continues to be guided by the principle that including the patient voice in healthcare improvement initiatives leads to increased quality, reduced costs, and greater value. Toward this end, MHQP will look to:

- Promote an understanding of patient engagement, and how MHQP can help providers, health plans, and patients improve patient engagement across ambulatory care
- Explore patient-reported outcomes measurement as a way to ensure that the performance metrics measured reflect the outcomes that matter most to patients
- Advance and modernize MHQP’s patient experience survey by driving improvements in scope, efficiency, and value



# New Jersey Health Care Quality Institute (Quality Institute)



## History

The New Jersey Health Care Quality Institute (Quality Institute) was founded in 1997 by David Knowlton, a former deputy health commissioner, to help purchasers of health care (employers, unions, and payers) determine if their money was being spent on the right care, at the right time. The premise was that if good quality care was achieved, price would be controlled. But at that time, it was difficult to find quality data. The Quality Institute was originally formed to serve as the quality arm of the Health Care Payers Coalition of New Jersey (a non-profit alliance of business and labor groups), publishing quality data to help payers select networks and negotiate.

The Quality Institute has transitioned to become its own non-profit and is recognized as an objective, nonpartisan organization working to ensure that the highest levels of healthcare quality, safety, transparency, and cost containment are achieved in New Jersey. Former New Jersey Governor Jim Florio, who is also a Quality Institute board member, noted that “the Quality Institute is willing to point out what’s not working and why; willing to question traditional wisdom; willing to take on the status quo, clarify the alternatives and, most importantly, bring substance to the table.”

The Quality Institute has more than 100 member organizations that represent every healthcare interest: providers and payers, patients and policymakers, innovators and industry veterans. Its board is comprised of some of New Jersey’s most influential thought leaders, and brings experience from all perspectives on the healthcare industry.

The Quality Institute’s funding derives from membership dues and grants from organizations such as The Nicholson Foundation, United Health Foundation, Horizon Foundation, Walmart Foundation, and CMS (as a State Innovation Model sub-grantee). Additional funding comes from membership contributions, sponsorships, and direct revenue from services.

## Leadership

The Quality Institute was initially led by President and CEO David Knowlton. Linda Schwimmer assumed the role in 2015. Prior to joining the Quality Institute, Schwimmer was Director of Strategic Relations and External Affairs at Horizon Healthcare Innovations, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. While at Horizon, Schwimmer served on the leadership team that brought Accountable Care Organizations (ACOs) and the largest Patient Centered Medical Home program to New Jersey.

## Strategies

The Quality Institute undertakes projects that ensure quality, accountability, and cost containment are all closely linked to the delivery of healthcare services. The Quality Institute’s members want to improve New Jersey’s healthcare system by bringing quality and affordability issues to the forefront. By bringing disparate views to the table, the Quality Institute works to find areas of consensus and identify innovative solutions to the many complex issues facing those who deliver, pay for, and receive care. Public education, transparency, collaboration, and problem-solving are the Quality Institute’s hallmark strategies.

### Services/Expertise

The Quality Institute is on the cutting edge of healthcare issues and is recognized across the state and region as an innovator, advocate, and leader for improved healthcare quality. The organization is often called upon by healthcare leaders and policy makers to create consensus and identify solutions to difficult policy issues. The Quality Institute supports and gets involved in a variety of programs and projects, including:

*The QI Collaborative:* A learning network for redesigning the healthcare system using new payment models, delivery system reforms, and community-based partnerships. Recognizing that accountable care initiatives represent an opportunity to achieve better

care at lower cost, the Quality Institute developed a partnership and learning network to serve the growing number of ACOs and other community-based integrated healthcare systems. By sharing best practices, tackling common challenges, and building new partnerships, the Collaborative facilitates the development and success of Medicaid ACOs and is supporting the work of the Practice Transformation Network grant from CMS.

*The Mayors Wellness Campaign:* A resource, deployed in more than 380 municipalities, that equips mayors with tools and strategies to champion healthy living in their communities. Municipalities have hosted walks, bike rides, healthy cooking classes, self-defense classes,

and wellness fairs, among other events, to offer residents creative ways to stay active year round. The newest initiative, called the Conversation of a Lifetime, launched in 2015 to help communities engage in thoughtful dialogue about advance care planning.

*Medicaid 2.0:* The Quality Institute is convening all stakeholders involved in the delivery and payment of Medicaid services to conduct an intensive review of the state Medicaid system. The goal is to create a blueprint for a system redesign that will improve both care and affordability of this essential part of the healthcare marketplace.

*Health Matters Poll:* A method to measure the attitudes of New Jersey consumers on current healthcare issues. Topics have included public opinion of the Affordable Care Act, insurance coverage attitudes, and end-of-life healthcare wishes. The results of these polls are often used as a valuable tool to promote a healthcare quality agenda in both the public and legislative arenas.

*The Leapfrog Group:* Thanks in part to the Quality Institute's efforts, New Jersey is one of the top states for the highest percentage of eligible hospitals that answer the Leapfrog Hospital Survey, which provides current, relevant information so employers and consumers can advocate for improved healthcare quality, safety, and transparency. Schwimmer holds an appointment to The Leapfrog Group's Board of Directors.

The Quality Institute hosts several conferences each year with a focus on healthcare issues including consumer choice, narrow health insurance networks, and disruptive innovations in cancer care. Additionally, the QI Collaborative hosts webinars, learning trips, and meetings to benefit the ACOs. Quality Institute staff and members convene the key parties when healthcare policy is discussed, crafted, implemented, and studied.

### Networks/Partnerships

The Quality Institute partners with many organizations to advance patient safety. Three key partnerships include:

- Joint project with the Nurse Practitioner Healthcare Foundation "Advancing Healthcare Access, Workforce Development, and Primary Care Services in New Jersey," funded by The Nicholson Foundation, includes three deliverables:



Red Bank Walk

a feasibility study for the City of Trenton; a feasibility study for the city of Newark; and a Nurse Practitioner Practice Toolkit.

- **National Quality Forum (NQF)**

For years, the Quality Institute has been a member of NQF, which is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care. It leads a national collaboration to improve health and healthcare quality through endorsing measurements. In 2015, Schwimmer became a member of the Consensus Standards Approval Committee (CSAC), a standing committee of the NQF Board of Directors which makes endorsement decisions regarding national voluntary consensus standards.

- **The Leapfrog Group**

As the Regional Leader for Leapfrog, the Quality Institute is responsible for encouraging hospitals to publicly report their data through the Leapfrog Hospital Survey.

### **Major Accomplishments**

The Quality Institute has always been an advocate for patient safety and healthcare quality. That, coupled with the organization's data-driven research and ability to bring all parties together to resolve difficult issues, has led to numerous policy improvements. The result is increased transparency, better quality of care, and reduced costs and medical errors, evidenced by:

- Encouraging hospitals to publicly report data through the Leapfrog Hospital Survey. As of the fall of 2015, New Jersey had the fourth-highest participation rate in the survey, and was the fifth-highest performing state. Four New Jersey hospitals were awarded The Leapfrog Group's Top Hospital designation.
- Facilitating the creation of five Medicaid ACOs to improve care to underserved populations in the state
- Establishing the Mayors Wellness Campaign
- Leading a one-year, intensive review to improve the effectiveness and sustainability of the state Medicaid system

The Quality Institute is particularly proud of its improvements in consumer protection, including playing a role in legislation related to caregiver support, hospital-acquired infection and patient safety reporting requirements, the creation of a drug price registry, and healthcare consumer information standards. It has also supported consumers through its ACO Medicaid Demonstration Project, and by creating a transparency report on New Jersey ambulatory surgery centers and surgical practices.

### **Why Join NRHI**

The Quality Institute joined NRHI in early 2015. NRHI's mission and that of the Quality Institute are closely aligned, and its member organizations perform similar work. Becoming part of NRHI provides the Quality Institute with access to information and potential collaborators, a peer group, an identity that is understandable in a broader context, and new funding opportunities to perform the valuable work of creating safer, value-based health care.

### **The Future**

The Quality Institute will further its work to drive down costs, improve quality, empower patients through better transparency, and support efforts to allow all New Jersey residents to gain access to high-quality, affordable care.



## Pittsburgh Regional Health Initiative (PRHI)

### History

The Pittsburgh Regional Health Initiative (PRHI) began with an effort in 1997 to position the Pittsburgh region competitively by achieving “best in class” status in a few select areas. Business leaders from the Allegheny Conference on Community Development aspired to create the highest value (best quality at lowest cost) health care in the U.S. What started as the *Working Together Consortium* eventually culminated in the creation of PRHI. Led by business and civic leaders, the PRHI board includes healthcare providers, clinicians, insurers, purchasers, academics, other local consumer and business health coalitions, and regional hospital and medical associations.

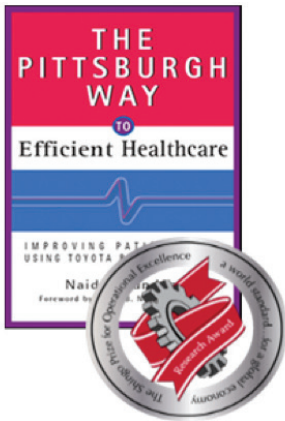
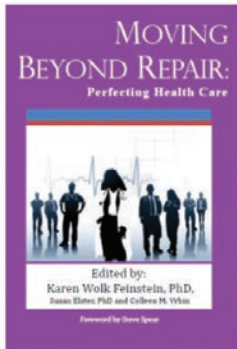
PRHI benefits from being a supporting organization of the Jewish Healthcare Foundation (JHF), which has an endowment of approximately \$140 million. But PRHI has also attracted an estimated \$40 million in external public and private funding.

PRHI was among the first regional collaboratives to focus on care improvement at the front line, rallying clinical champions to use its Perfecting Patient Care<sup>SM</sup> (PPC) process improvement method to prove that delivering best practices without error or waste saves lives and money in acute, long-term, and ambulatory care settings. Today it develops and manages innovative programs, testing new models of care informed by its own research while continuing to provide training and coaching to managers, frontline staff, and students.

Adapting Lean quality improvement tools developed by W. Edwards Deming, applied by the Toyota Motor Company, and later championed by Paul O’Neill at Alcoa, PRHI set about bringing Lean methods to health care. One of the first healthcare problems at which PRHI took aim was hospital-acquired infections (HAIs) – the source of many of the avoidable deaths. Beginning around 1999, PRHI recruited 44 hospitals in southwestern Pennsylvania as founding members of the initiative, and partnered with the Centers for Disease Control and Prevention. Together these institutions reduced central line infections by 68% while also reducing costs by 30–40%. In addition, PRHI guided the VA Pittsburgh Healthcare System in developing a MRSA prevention protocol and interventions that led to an 85% reduction in MRSA infections. The MRSA prevention protocol became standard practice across the national VA Healthcare System.

PRHI’s infection reduction work caught the attention of Pennsylvania Governor Ed Rendell’s Office of Health Care Reform, and contributed to the passage of Act 52 of 2007, the strongest HAI legislation in the country. It tied continued hospital licensure to successfully reducing HAIs, and led to a 24% reduction in HAIs in the first three years of reporting.

PRHI also demonstrated success in areas other than infection reduction, including a 40% reduction in 30-day readmissions for patients with Chronic Obstructive Pulmonary Disease (COPD) and then for persons living with HIV/AIDS. Within a decade, PRHI trained thousands of healthcare workers in Lean methods and reported successes in improving quality in virtually every kind of healthcare setting. Many of these stories were captured by Naida Grunden in her 2007 book, *The Pittsburgh Way* (winner of the 2013 Shingo Prize), and, in the same year, by Atul Gawande in *Better: A Surgeon’s Notes on Performance*.



Books highlighting PRHI's journey

## Leadership

Since its inception, PRHI has been guided by Karen Wolk Feinstein, PhD, president and CEO of JHF and its two supporting organizations – PRHI and Health Careers Futures (HCF). Dr. Feinstein previously held faculty positions at two universities and executive posts at other nonprofits. She is a past Chair of Grantmakers In Health and Grantmakers of Western Pennsylvania, and co-Chair of the Pennsylvania Health Funders Collaborative.

PRHI's co-founder, former Alcoa Chairman and U.S. Treasury Secretary Paul O'Neill, was instrumental in developing the founding vision of PRHI. He believed that the industrial engineering processes (such as the Toyota Production System) that helped to make Alcoa the safest organization in the world would work equally well to improve the quality and cost problems of health care. Ken Segel and Geoff Webster, now principals in Value Capture, also offered valuable early leadership.

## Strategies

PRHI believes that Lean is an enterprise-wide solution to quality improvement that must permeate all levels within an organization – it is not a Band-Aid to be applied to select problems for spot repair. PRHI works to achieve dramatic changes in the quality, safety, reliability, and efficiency of care by empowering healthcare workers at all levels with training, coaching, and technical assistance.

## Services/Expertise

PRHI engages in model development, demonstration projects, research, education, leadership development, practice transformation, end-of-life training, quality improvement training, and coaching in Lean methods and tools.

PRHI has advised local, state, and national government on policies and practices related to issues including healthcare safety and error reduction; new models of payment and delivery; behavioral health integration with primary care; women's health; successful aging; long-term care; end-of-life care; access to health care; workforce development; and immunizations.

To date, PRHI has trained more than 9,000 healthcare professionals from around the globe – including doctors, nurses, pharmacists, administrators, and technicians – in its Perfecting Patient Care<sup>SM</sup> (PPC) methodology. The lessons learned through PPC have measurably reduced hospital-acquired infections and patient falls; hospital readmissions among patients with chronic diseases; and improved the quality of care in intensive care units, pathology labs, nursing homes, primary care practices, and community health centers, among other settings. In addition, PRHI has engaged with more than 750 multi-disciplinary students through its Fellowship programs and many others through its Champions and internship programs, developing an army of change agents in the process.





PRHI and the region set a national record when more than 80 employers signed onto U.S. HHS Secretary Michael Leavitt's "Four Cornerstones of Value-Driven Health Care" (March 2007)

### **Networks/Partnerships**

PRHI and its parent organization, JHF, have more than 25 years of experience in convening stakeholders on topics related to safety, quality improvement, readmissions reduction, and primary care integration, as well as public health issues like women's heart health, end-of-life care, and HPV vaccinations.

In partnership with the Pennsylvania Workforce Investment Board, JHF hosted a regional Health Workforce Summit in 2001 to identify gaps in workforce training, recruitment, and retention. This inspired the initiation of PRHI's sister organization, HCF.

Following an outbreak of Legionella at the VA Pittsburgh Healthcare System, the CDC turned to PRHI to craft a community response aimed at preventing future outbreaks of the potentially deadly bacteria. PRHI and the Allegheny County Health Department issued updated guidelines in 2014 on testing for and mitigating the risk of Legionella.

### **Major Accomplishments**

PRHI's areas of focus have evolved over its near-20-year history:

#### **Stage One: Demonstrating that Lean Quality Engineering Principles Work in Health Care**

During its early years, PRHI experienced success in improving care quality and efficiency through Lean methods, initially in hospitals. This led to invitations to speak around the globe and across the U.S. PRHI also shed light on healthcare's perverse payment system; for example, PRHI consultant Harold Miller and CEO Karen Feinstein described how hospitals were rewarded financially for HAIs – a finding that was featured on the cover of *Modern Healthcare* in 2007.

#### **Stage Two: Keeping People Out of Hospitals**

PRHI eventually shifted attention to improving the outcomes of primary care teams through practice transformation, and by activating patients to become leaders of their healthcare team. This newer goal spurred multi-million dollar, private and federally-funded demonstration projects:

- **The Safety Net Medical Home Initiative:** A four-year (2009-13) program, funded by the Commonwealth Fund, led to the successful transformation of safety net practices into patient-centered medical homes.
- **Regional Extension and Assistance Center for Health Information Technology for western Pennsylvania (PA REACH West):** Funded by the Office of the National Coordinator for Health IT (ONC-HIT) from 2010-16, PRHI guided 305 primary care practices and 763 providers to implement EHRs (96% of those practices are using EHRs, and 91% achieved Meaningful Use).
- **Integrating Behavioral Health in Primary Care:** In 2008, PRHI’s researchers discovered that many patients with frequent hospital admissions for chronic diseases also had behavioral health problems like depression and substance use disorders. Several demonstration projects resulted: the locally-funded Integrating Treatment in Primary Care (ITPC) followed by AHRQ-funded Partners in Integrated Care (PIC), and finally CMMI-funded and Institute for Clinical Systems Improvement-led, Care of Mental, Physical, and Substance Use Syndromes (COMPASS). Through COMPASS, 72% of patients significantly improved their depression while 28% achieved depression remission. Fifty-nine percent of those patients had an A1C (blood glucose level) of less than eight, compared to 42% at baseline; and 60% controlled previously high blood pressure.
- **Reduce Avoidable Hospitalizations using Evidence-based interventions for Nursing Facility Residents (RAVEN):** A CMMI-funded local collaboration to reduce avoidable hospitalizations among long-stay nursing home residents in 18 long-term care facilities in western Pennsylvania. To date, all-cause hospitalizations have decreased by 21.9%, potentially avoidable hospitalizations by 24.3%, and potentially avoidable emergency department visits by 40.8%, resulting in an estimated savings of more than \$5 million and a four-year grant renewal.



Harold Miller and  
Karen Wolk Feinstein  
(December 2007)

- **Primary Care Resource Center (PCRC):** A unique model for reducing readmissions, culminating in 2012 in a \$10.4 million award from CMMI to establish six hospital Primary Care Resource Centers to offer complex patients one-stop, coordinated outpatient care. The project focused on patients with chronic obstructive pulmonary disease, acute myocardial infarctions, and/or heart failure. Collectively, the PCRCs achieved a 25% reduction in 30-day hospital readmissions, and reduced the 90-day total costs of care by more than \$1,000 per Medicare patient.

### Stage Three: Empowering frontline workers and consumers

- **Positive Deviance Initiative:** A study of high performers among local long-term care facilities, hospitals, and medical groups, with the goal of uncovering key elements that contribute to success and disseminating best practices.
- **Tomorrow's HealthCare™:** Expanded deployment of PRHI's signature online knowledge platform to align key stakeholders around improvement strategies, achieve a higher-performing system overall, and articulate and shape a vision of a robust system of the future.

### Why Join NRHI

In 2004, Dr. Feinstein and Dr. Gordon Mosser from Minnesota's Institute for Clinical Systems Improvement (spurred on by Sophia Chang of the California Health Care Foundation) convened other regional collaboratives committed to quality improvement (including the Pacific Business Group on Health, Massachusetts Health Quality Partners, Minnesota Community Measurement, Quality Quest for Health of Illinois, and the Wisconsin Collaborative for Healthcare Quality) and established NRHI as a national association to advance common goals. The primary goal was to gather strength through association and that objective has been decidedly met.



“For achieving transparency, it’s important to get input from those being measured. And for them to create measures, you need a structure. If organizations come together, they exert peer pressure on one another. They challenge high performers to reach new heights, and pressure low performers to step it up.”

“Karen and I had talks on fostering a national organization. [She] was incredibly energetic. She was a doer, and had resources. She would bring to bear what’s needed to get space and hire staff. NRHI has brought different associations together to see what’s being done, and see if it could be replicated and adapted to other locales.”

Gordon Mosser, MD  
Co-founder and President of ICSI  
from 1993-2006

### The Future

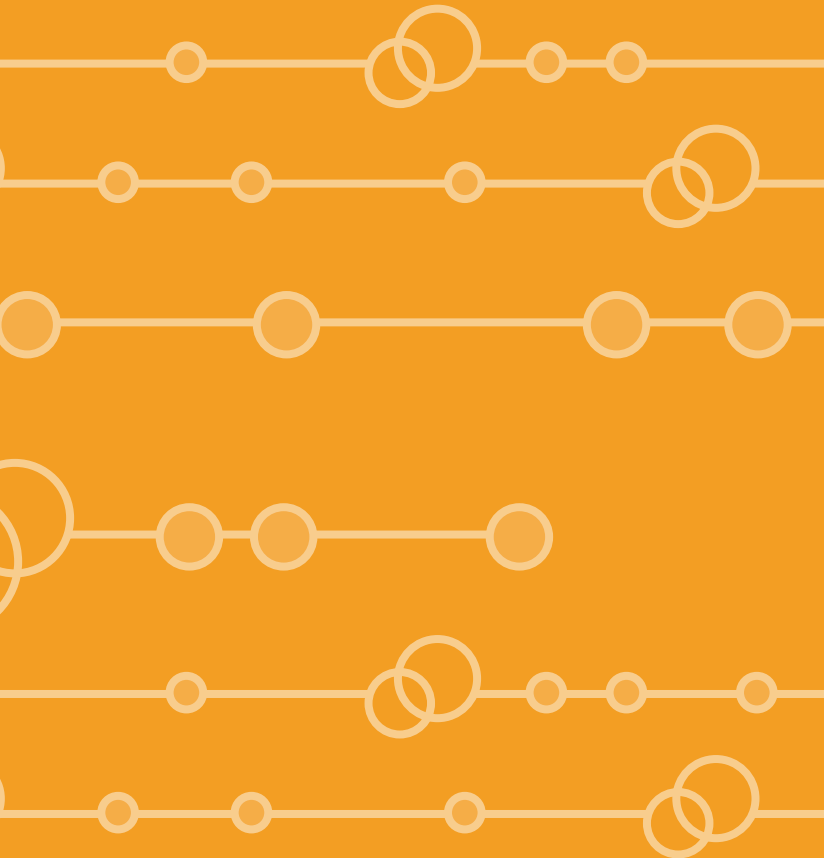
PRHI will support innovative models of primary care and prevention that address the social determinants of health, and equip patients with the knowledge to make informed health choices. Also, PRHI seeks to strengthen home and community-based living options for seniors, and to create a model of excellence for adolescent behavioral health prevention and treatment. PRHI will champion new high-value members of healthcare teams, such as community health workers, while training and educating individuals – from burgeoning professionals to seasoned veterans – to deliver data-informed, effective services in partnership with local social and behavior health providers.



Patient Safety Fellows - 2015



# Region: Midwest





# Greater Detroit Area Health Council (GDAHC)



## History

The Greater Detroit Area Health Council (GDAHC) was founded as the Greater Detroit Area Hospital Council in 1944 to oversee community health planning activities during a period of rapid expansion of hospital capacity. A restructuring in the 1980s led to the current name. GDAHC's mission is to improve the health and economic well-being of individuals, organizations, and communities by leading innovative and transformational programs.

To achieve this mission, GDAHC works to increase care access and manage the cost of care, connect cross-sector and multi-stakeholder partners (those who get care, give care and pay for care) to assure community-wide support and participation in the programs, integrate social services with clinical care, promote good health as a basis for economic viability, use data to drive action and improve health outcomes, and educate the community.

GDAHC hosted a community consensus project in the early 2000s, known as Future Directions, to revitalize its mission and energize community leaders to take an active role in redesigning the future of health care. As a result of this consensus initiative, southeast Michigan embarked on "Save Lives, Save Dollars," a five-year project designed to improve healthcare quality and reduce costs by five percent. Payment reform, data transparency, utilization management, use of evidence-based care protocols, initiatives around emergency department utilization, low back pain, and overprescribing of antibiotics were hallmarks of the work accomplished under this initiative.

"Save Lives, Save Dollars" was a precursor to the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality (AF4Q) program, for which GDAHC was one of the first communities selected as an awardee. In addition, GDAHC was one of the original 13 communities designated by the U.S. Agency for Healthcare Research and Quality as a Chartered Value Exchange.

## Leadership

Kate Kohn-Parrott, MBA, CMA, CIA, serves as GDAHC's President and CEO. The executive committee provides operational governance and guidance as needed. To ensure all voices and needs are considered in proposed work, each type of GDAHC member organization is represented on the committee, which signs off on all major initiatives.

## Strategies

Efforts to address health disparities, population health, clinical quality, education, learning, and workforce development are integrated into each GDAHC initiative. GDAHC's work generally falls into three categories: connecting (understanding and exceeding member expectations), measuring (using data to improve health), and transforming (linking health care and social services).

To effectively address these categories, GDAHC maintains a nimble and flexible implementation structure. GDAHC and partners examine preliminary data to conduct quick improvement cycles, in a typical "Plan-Do-Study-Act" fashion. For stakeholders, sites, and individuals involved in project implementation, GDAHC has a variety of project management strategies to move the needle toward success, including convening project-based team meetings and learning networks through in-person and phone meetings, and webinars.

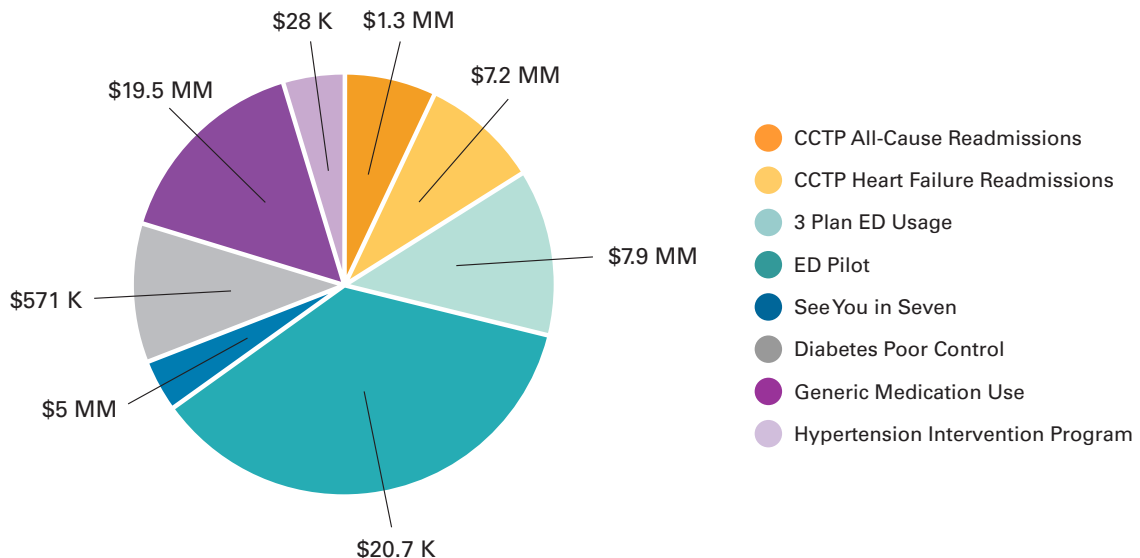
### Services/Expertise

GDAHC partners with its members on public reporting, data transparency, patient experience of care, and other member-centric initiatives. GDAHC works with consumers and providers on education and awareness, and convenes workgroups dedicated to addressing disparities in care. In particular, GDAHC provides education and organizes conversations on controversial topics through a breakfast series called “Coffee and Controversy.” Recently, the organization convened a community summit on opioid and heroin abuse, and is in the process of drafting a work plan to address concerns cited at the summit. Beyond this, GDAHC facilitates initiatives to improve economic conditions and help draw investments to Detroit’s neighborhoods.

GDAHC also directs the Southeast Michigan Regional Area Health Education Center (SERC AHEC), a Health Resources and Services Administration program, in coordination with Wayne State University. AHEC works to improve access to primary care for all Michigan residents, many of whom live in areas that have too few health professionals. Through recruitment and retention initiatives, as well as special clinical education programs, AHEC seeks to expose disadvantaged students to health career opportunities, expand the number of under-represented minorities in the health professions, and encourage students and health professionals to work in areas that need greater access to primary care providers.

GDAHC actively helps local governments and businesses understand the health landscape, and also partners with the state of Michigan on a variety of health-related matters. GDAHC staff also participate on a number of outside committees and advisories, including the Automotive Industry Action Group Health Value Task Force, Michigan Primary Care Consortium; Michigan Consumers for Healthcare; Population Health Council; Blue Cross Blue Shield of Michigan (BCBSM) Physician Group Incentive Program; Detroit Regional Infant Mortality Reduction Task Force; Detroit Institute for Equity in Birth Outcomes; New Detroit Trustee and Member of Institutional Practices Committee; Michigan Cancer Consortium; Medical Care Advisory Council; Wayne State University College of Nursing Board of Visitors; and the Voices of Detroit Initiative.

### GDAHC Initiatives’ Impact Total Cost Savings: \$41.5 MM



## **Networks/Partnerships**

BCBSM created its Physician Group Incentive Program (PGIP) as a result of GDAHC galvanizing the community to align incentives around outcomes through the “Save Lives, Save Dollars” program. Today, BCBSM’s PGIP program is nationally recognized as an early adopter and leader in outcomes-based payment.

Since successful initiatives rely on collaboration, GDAHC partners with several health advancement organizations locally in southeast Michigan and across the state. These include local health departments, the state of Michigan, the Center for Health Research and Transformation, the Institute for Population Health, the Michigan Public Health Institute, and the Population Health Council, among others. Nationally, GDAHC formed partnerships through its membership in NRHI, and through its status as an RWJF AF4Q and CVE community.

## **Major Accomplishments**

GDAHC has successfully coalesced disparate stakeholders around a neutral table, with an agreed upon mission and collective goals. Coordination and collaboration are the hallmarks of GDAHC’s longevity and represent the services most desired by GDAHC’s members. GDAHC’s members stay at the table because of the relationships they are able to build and nurture across the community, and the collective impact they are able to advance as part of the GDAHC collaborative.

“Save Lives, Save Dollars” wasn’t an anomaly when it comes to successful initiatives that result in cost savings. GDAHC determined that more than \$41 million was returned to the community as a result of pilot projects implemented during its three final years of participating in the RWJF AF4Q program.

GDAHC is particularly proud of its work around public reporting (which contributed to an increase in generic prescribing, improved diabetes control, and more immunizations), reducing ED utilization (including an 85% reduction in ED usage within one physician organization), care coordination, and hospital readmissions reductions.

## **Why Join NRHI**

GDAHC was an early member of NRHI. GDAHC has worked for years on payment reform, public reporting, and data transparency. Since NRHI offers a great avenue for partnerships and collaborations, GDAHC worked with them on elevating this work to the national stage.

GDAHC considers NRHI to be an invaluable resource in learning about the outstanding efforts of similar, mission-driven organizations across the county. NRHI provides a network for sharing knowledge, best practices, lessons learned, ideas, and much more. GDAHC knows that when the organization confronts a problem, staff can pick up the phone and dial a fellow NRHI member who is struggling with, or has resolved, a similar challenge.

## **The Future**

GDAHC is working diligently to reinvent itself as the facilitator and link between clinical care and the social determinants of health across communities. GDAHC believes that such whole-person care is critical to addressing patient outcomes, efficiency, and costs. Recently, GDAHC joined forces with several other organizations in the Detroit area to be the lead and bridge organization on the CMS Accountable Health Communities grant. Community support for GDAHC in this important position is a testament to the organization’s role as a convener and catalyst for whole-person health.

## Healthcare Collaborative of Greater Columbus (HCGC)



### History

The Healthcare Collaborative of Greater Columbus (HCGC) was formed in 2003 as Access HealthColumbus in order to improve access to health care for the vulnerable population in Greater Columbus. From 2003-2009, the organization created the Voluntary Care Network (VCN), which was designed to organize a charitable network of specialists providing services in their offices for low-income patients who have primary care relationships with community health centers. The VCN, supported by care coordination, access to affordable prescription drugs, transportation assistance, and interpreter services, has provided over \$50 million in charitable health care and is currently operated by a separate non-profit organization (Physicians CareConnection).

HCGC shifted its focus in 2010 to improve primary care delivery for all people – not just those most vulnerable – with a mission of transforming healthcare delivery and value for Greater Columbus through collaboration with providers, purchasers, and social services. In 2014, the organization changed to its current name to better align with its role as a convener, catalyst, and coordinator of regional healthcare improvement projects. HCGC is a non-profit, public-private partnership.

### Leadership

Jeff Biehl has served as HCGC's president and strategist since the organization's founding. Biehl's experience is rooted in health services administration since 1985 in Columbus, Nashville, and Pittsburgh. He has diverse experience including building collaborative solutions, business development, health information technology, managed care administration, physician practice management, and social entrepreneurship. The organization currently has three additional staff leaders who function as healthcare improvement consultants – Krista Stock, John Leite, and Michelle Missler.

### Strategies

HCGC is focused on the following four strategic areas, which are aligned with the National Quality Strategy:

- Fostering collaborative learning by hosting a safe space with regional partners to explore results-based practices and apply learning
- Advancing primary care to improve access, care coordination, and patient engagement, resulting in high-value patient-centered medical homes
- Enhancing the measurement and sharing of data to improve quality and transparency
- Expanding the adoption of results-based practices to reduce variation, thereby creating a medical neighborhood to impact chronic conditions

## **Services/Expertise**

To improve community health and healthcare quality, HCGC focuses on a collaborative process to foster the following six key components:

- Trust – building collaborations with providers, purchasers, and social services. Trust is further enhanced through HCGCs efforts with quality improvement projects, including their contributions to the following collaboratives:
  - Ohio’s State Innovation Model (SIM) Initiative
  - SW Ohio Comprehensive Primary Care (CPC) Initiative
  - Ohio Patient-Centered Primary Care Collaborative (OPCPCC)
  - Franklin County Pathways Community Hub
- Awareness – catalyzing best practices with a focus on quality improvement, including spreading the adoption of results-based practices such as *Choosing Wisely*<sup>®</sup>, OpenNotes, patient/family engagement, and use of questions in health care. In addition, patient-centered medical homes have established care coordination functions in primary care that help patients navigate the complexities of health care.
- Exploration – convening diverse stakeholders using Collective Impact methods
- Commitment – coordinating quality improvement projects that transform healthcare delivery
- Collective Impact – quantifying progress and communicating results in a transparent way
- Spreading Knowledge – hosting regional learning collaborative groups, including:
  - Behavioral Health Learning Group
  - Medical Neighborhood Learning Group
  - Navigator & Certified Application Counselor Learning Group
  - Purchaser Learning Group
  - Quality Improvement Learning Group
  - Regional Learning Sessions

## **Networks/Partnerships**

HCGC is a catalyst for spreading PCMHs in private practices, hospital-based practices, and community health centers. They are currently leveraging their relationships, trust, and 14-year reputation to advance the medical neighborhood, which in turn will continue to strengthen clinical and community relationships.

HCGC has a longstanding relationship with RHICs in Cleveland and Cincinnati, along with the Governor’s Office of Health Transformation (OHT), which operates the CMMI State Innovation Model (SIM) grant for Ohio. HCGC is a strategic partner on the SIM grant to align public-private payments to reward value-based health care.



### **Major Accomplishments**

HCGCs multi-year PCMH project brought together leaders from primary care organizations and health plans to design a pilot program which incorporated payment innovation and measurements. It took more than two years to build and nurture the relationships and trust toward advancing the PCMH model through a collaborative process. The majority of the 140 PCMHs that are providing high-value health care to more than 500,000 patients are in value-based payment arrangements and are demonstrating their value. Learnings from this work were used to secure Ohio's SIM grant.

HCGC has advanced the transparency of quality metrics, with more than 130 practice sites sharing data on cancer, diabetes, and high blood pressure management. The data, representing over 200,000 patient lives, was used to achieve performance improvements in all three measures. On a similar note, HCGC established their area's first regional quality sharing website – [OurHealthcareQuality.org](http://OurHealthcareQuality.org) – using a physician-led approach.

In addition to their PCMH and quality transparency efforts, HCGC established the Charitable Pharmacy of Central Ohio, with over \$25 million in charitable prescription drugs.

### **Why Join NRHI**

HCGC joined NRHI in 2014 to expand its ability to learn from others doing similar work in other regions.

### **The Future**

HCGC will continue its mission to ensure optimal care, value, and health for all people in the Greater Columbus region. HCGC is funded by public and private sources using a framework to continue diversifying their sustainability. The core mission activity in this framework includes grants, sponsorships, and donations. HCGC operates a growing social enterprise that provides strategic consulting services and nonprofit leadership development services. Additional contributions come from earned income from non-profit (501(c)(3) and for-profit (LLC) business activities.

## History

The Institute for Clinical Systems Improvement (ICSI) was established in 1993 by HealthPartners, Mayo Clinic, and Park Nicollet Health Services as an independent, non-profit organization to improve patient care in Minnesota through innovations and partnerships in evidence-based medicine. ICSI's mission is to champion the cause of healthcare quality and to accelerate improvement in the value of the health care.

ICSI initially focused on developing evidence-based guidelines for preventing, diagnosing, treating, and managing numerous diseases and health conditions. As medical groups built their capacity to implement guidelines and use quality improvement strategies, ICSI began to lead learning collaboratives where medical groups shared information, tools, and strategies in support of common improvement goals. With an expanded, statewide reach, ICSI worked with community partners to identify priorities that included improving diabetes and depression care, expanding access to medical care, and ensuring patient safety.

Because quality improvement is not possible without robust measures, ICSI pioneered measure development as part of the guideline development process. The organization developed outcome, process, and patient-reported measures, with results from participating medical groups shared within the collaborative. This foundational work in measurement was instrumental in the community's support of Minnesota Community Measurement, a partnering RHIC that was established in 2005.

## Leadership

ICSI's original leadership team featured Executive Director Gordon Mosser, MD, and Board Chair James Reinertsen, MD. Currently, ICSI's leaders include Interim President and Chief Executive Officer Craig Acomb, MS; Chief Medical Officer Claire Neely, MD; and Vice President Cally Vinz, RN. Board membership has evolved as the collaborative has broadened and now includes representatives from Minnesota's rural and metro areas, including integrated healthcare system providers, federally qualified healthcare systems, payers, employers, and state agencies.

## Strategies

ICSI remains grounded in scientific evidence and quality improvement, constantly seeking innovative and proven models of care to disseminate to member groups, and testing new implementation methods to meet members' evolving needs. ICSI leverages proven strategies to create change, and combines these strategies with cutting-edge approaches and technology to disseminate and spread change within health care and beyond. With a collaborative approach and trust built among its diverse stakeholders, ICSI tackles some of the community's most complex health and healthcare system problems.

## Services/Expertise

ICSI offers a range of services, including:

- Bringing together various stakeholders to solve common problems identified by their members and region
- Disseminating and implementing evidence-based models of care to improve patient outcomes

- Assisting organizations in harnessing data to achieve their organizational goals
- Preparing stakeholders for value-based care delivery and payment models, and training leaders to adapt to a rapidly changing environment
- Integrating behavioral health and collaborative care in primary care
- Developing clinical practice guidelines that are recognized and adopted nationally and internationally
- Partnering with organizations on clinic-based research to better define and spread best practices and care models
- Offering quality improvement and other educational opportunities that support healthcare transformation



**3,000+** people have collaborated with ICSI on Quality Improvement over the years

#### **Quality Improvement**

Infrastructure and methodology are essential building blocks for any QI project/initiative and are required for innovation and change. ICSI has helped members and sponsors build this capability for more than 20 years.

ICSI hosts an annual “ICSI Colloquium” which offers innovative, forward-thinking programming from local and national speakers to approximately 350 attendees. ICSI also holds the annual “Reinertsen Lecture” for local health professionals and leaders, featuring a guest speaker on a prominent subject. In addition, ICSI hosts regularly scheduled workshops on quality improvement, motivational interviewing, culture, and leadership.

Established in 2010, the ICSI-sponsored Patient Advisory Council (PAC) provides a voice for patient and family-centered care elements vital to providing care, and is an invaluable resource of patient stories that demonstrates both excellence and opportunities for improvement. The PAC also awards its Seal of Approval to guidelines, training materials, and other initiatives that meet specific criteria.

ICSI’s leadership and staff serve on numerous national, state, and local committees and advisory panels, including the Minnesota eHealth Advisory Committee, Alzheimer’s Association Advisory Board, Health Care Home Advisory Committee and several sub-committees, State Innovation Model, Midwest Research Network, the board of another RHIC, and advisory panels for the regional Quality Improvement Network (QIN).

#### **Networks/Partnerships**

ICSI is a founding member of the Minnesota Shared Decision-Making Collaborative, which champions patients and clinicians working together to make healthcare decisions that incorporate the patient’s values and preferences, as well as the best medical evidence. ICSI’s extensive experience in this area includes development of the Collaborative Conversation™ framework, which helps organizations across the care continuum to implement shared decision-making.

Additionally, ICSI and Mayo Clinic are partners in an Agency for Healthcare Research and Quality (AHRQ) grant to disseminate evidence-based health information at the point of care. This study is investigating processes that enhance use of decision aids and shared decision-making at the point of care, including those related to osteoporosis, diabetes, hypertension, depression, and lipid medications.

ICSI frequently partners with state and public health agencies, professional healthcare associations, regional health collaboratives, and other stakeholders in Minnesota and across the nation in pursuit of the Triple Aim – improving the patient experience of care (including quality and satisfaction), improving population health, and reducing healthcare costs. ICSI has actively worked with the following organizations to meet the triple aim goals:

- State and Federal Organizations: Minnesota Department of Health (MDH), Minnesota Department of Human Services, Minnesota Department of Public Safety, Centers for Medicare and Medicaid Services (CMS), Center for Medicare & Medicaid Innovation (CMMI), Centers for Disease Control (CDC), AHRQ
- Regional Stakeholders: Minnesota Hospital Association, Minnesota Medical Association, Minnesota Council of Health Plans, Twin Cities Public Television
- National Partners: Guideline International Network (GIN) and GIN–North America, Kaiser Permanente, American Cancer Society, clinical specialty associations, NRHI Members
- Philanthropic: Robert Wood Johnson Foundation, Bush Foundation, Peterson Foundation, Penny George Foundation, American Indian Cancer Foundation, American Board of Internal Medicine Foundation
- Education Institutions: University of Minnesota, Normandale Community College
- Community Organizations: Minnesota Community Measurement, Stratis Health (QIO/QIN), ClearWay Minnesota, Minnesota Alliance for Patient Safety, Citizen’s League
- Employer Organizations: Minnesota Health Action Group, General Mills, Target, 3M, Best Buy

### **Major Accomplishments**

As a neutral convener, ICSI has brought together providers, payers, and other broad health stakeholders to achieve results including:

- The national Eisenberg Award-winning Reducing Avoidable Readmissions Effectively (RARE) Campaign, which prevented nearly 8,000 avoidable hospital readmissions and saved Minnesota more than \$70 million
- The Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program, which is changing how care for patients with depression is delivered and paid for in primary care
- The High Tech Diagnostic Imaging (HTDI) initiative, which enabled the ordering of appropriate advanced diagnostic imaging scans using decision-support criteria, and influenced CMS to support this approach for ordering HTDI scans nationwide. This work saved Minnesota an estimated \$234 million.
- Following passage of the 2008 Health Care Home legislation, ICSI adopted healthcare home as a strategic initiative. This work supported the development of Minnesota’s healthcare home model, standards, and outcomes.
- CMS funded a three-year project where ICSI led a consortium of 18 medical groups implementing the COMPASS (Care Of Mental, Physical and Substance-use Syndromes) model in 200 primary care clinics in eight states

- In 2010, ICSI facilitated an MDH project called Baskets of Care that defined seven baskets of care meant to help consumers compare the value of services offered by different providers
- In 2011, ICSI hosted a Summit on Total Cost of Care attended by over 100 Minnesota healthcare leaders and stakeholders. This collaborative educational and conversational opportunity prepared Minnesota to more fully embrace the inclusion of cost as a legitimate aspect of the Triple Aim.
- ICSI participated from 2010-2012 in an MDH Statewide Health Improvement Project (SHIP), which worked to prevent disease by creating healthy communities and helping individuals make healthy choices. ICSI led collaboratives across Minnesota in which medical groups worked with public health agencies to implement the ICSI Healthy Lifestyles and Obesity guidelines. ICSI also helped two counties implement a clinic-based referral system to local agencies to help patients increase their physical activity and improve nutrition.
- In response to requests in 2015 by the MDH and collaborative members, ICSI convened a work group to develop guidance for ambulatory care practitioners to understand their role in certifying Minnesota patients who may be eligible to receive medical cannabis. The resulting guidance document was approved by MDH, and is available on the MDH/ Office of Medical Cannabis website.
- Since 2013, ICSI has convened a group of stakeholders interested in global health measurement that includes member organizations and MN Community Measurement

### Why Join NRHI

ICSI was a founding member of NRHI, immediately recognizing the value in collaborating with fellow healthcare improvement organizations across the country to share expertise, continuously learn, and stay informed about activities and developments on a national level. Through its relationship with NRHI, ICSI has also enhanced its skills in communicating with policy makers.

### Integrating Behavioral Health

ICSI has extensive experience in integrating behavioral health into primary care and in bringing quality improvement, screening, measurement and other components into the mental health field.

**59%** of patients with depression showed significant improvement; diabetes control improved by **23%**; hypertension control improved by **58%** in COMPASS program

**36,000** patients screened for risky substance use, as a result of our DIAMOND/SBIRT initiative

### The Future

With health care continuing to evolve rapidly, ICSI recognizes the need for a coordinated community approach to robust measurement, clinical care innovation, aligned payment models, and consumer engagement. ICSI has broadened its constituency to serve new stakeholders, focusing on the full scope of the triple aim – including smarter spending. ICSI has built and maintained a healthcare quality improvement environment, partnering with organizations that simultaneously collaborate and compete. ICSI continues to convene organizations to address complex healthcare issues that no single organization can address as effectively and broadly.



# Midwest Health Initiative (MHI)



## History

The Midwest Health Initiative (MHI) was founded in 2010 to improve the quality and affordability of health care in Missouri and its bordering metropolitan areas, including eastern Kansas and western Illinois. Initially developed by the St. Louis Area Business Health Coalition (BHC) and its health plan partners, MHI is currently led by a multi-stakeholder board which includes physicians, hospitals, employers, health plans, and consumer representatives.

## Leadership

Louise Probst RN, MBA, has served as the executive director since MHI's inception. While MHI is a purchaser-led collaborative, the organization incorporates multi-stakeholder input into all of its decision making to best support the long-term community interest.

## Strategies

MHI serves as a trusted information source and a neutral convener for stakeholders to identify shared health improvement priorities and work toward achieving common goals. MHI stewards an aggregated data set with up-to-date medical and pharmacy claims information on 1.4 million commercially-insured individuals across the state of Missouri and adjacent metro areas.

## Services/Expertise

After sharing initial quality data with local physicians, MHI now licenses its dataset to healthcare organizations, the St. Louis Area BHC, and health plans to support them in elevating care quality, efficiency, and outcomes. Results are shared with providers through the CareWell portal, which supports physicians in accessing information to benchmark how often their patients receive care in line with nationally recognized measures of quality.

With its data-driven approach, MHI serves as a catalyst for identifying and addressing community health issues, and measuring the effectiveness of interventions. To coordinate with specific community-wide initiatives, MHI supports its partners in sharing educational material with consumers. For example, hospitals, physicians, employers, and health plans who have partnered with MHI distributed March of Dimes materials to consumers regarding the risk of early elective deliveries as part of the Healthier Babies initiative.

## Networks/Partnerships

MHI connects with its partners through bi-monthly council meetings and quarterly board meetings. It gathers the larger community to present data and generate dialogue around topics of interest, including hosting:

- Physician leaders to show comparative results on Total Cost of Care (TCOC) as well as related quality data
- 80 community leaders to learn about TCOC results, with an emphasis on how potentially wasted dollars could have been better spent on non-healthcare goods and services
- Obstetrics nurses and physician leaders with representatives of employers, health plans, and consumers to discuss early elective delivery and develop a shared, coordinated plan to address it

- More than 200 employers, health and wellness enthusiasts, and community members for the launch of LiveWellSTL.org, a website that connects users to healthy activities and events that meet their interests and budgets

MHI works closely with the BHC, which supports more than 50 St. Louis employers in improving the health of their enrollees and getting the most out of their investments in health benefits. MHI also partners with the St. Louis University School of Outcomes Research.

In addition to engaging in and providing input to numerous national and local initiatives, including the Learning and Action Network (LAN) and National Business Coalition on Health (NBCH), MHI and BHC staff participate in the following organizations as board or committee members: the National Quality Forum, Measure Applications Partnership Hospital Workgroup, Consumer-Purchaser Alliance Advisory Council, National Committee for Quality Assurance, STL Healthy Communities, St. Louis Board of Health, Missouri Health Connection, Missouri Health Policy Forum, St. Louis Maternal, Child and Family Health Coalition, and the St. Louis Antibiotic Resistance Can Harm effort.

### **Major Accomplishments**

The Healthier Babies initiative aligned nearly 50 partners to develop and implement consistent policies, processes, and messaging regarding the risk of inductions and cesarean sections before 39 weeks of pregnancy. Key components included:

- A community policy statement signed by healthcare providers, employers, health plans, consumer advocacy groups, and medical societies
- A policy and procedures manual developed by the region's Maternal Child and Family Health Coalition through a workgroup of obstetrics nurse managers
- Distributing thousands of March of Dimes materials and messaging to mothers-to-be through physicians, employers, and health plans
- Public reporting of hospitals' early elective delivery rates by the BHC

The LiveWellSTL.org website connects more than 20,000 users each year to healthy activities and events in the St. Louis region, from more than 2,500 listings which are updated daily.

### **Why Join NRHI**

MHI joined NRHI to connect with others seeking to improve community health, as well as the quality and affordability of health care. MHI values the ability to learn from and with others through the NRHI-coordinated TCOC project. The collaborative nature of NRHI's staff and members makes it easy to reach out and leverage the experiences of members, and continually learn through in-person and virtual forums. NRHI has evolved into a vibrant, member-driven organization that understands the specific goals of each member, and supports them with relevant insights and connections to regional and national organizations.

### **The Future**

In 2016, MHI will launch the ChooseWell website, which will share comparative quality and efficiency information on physician practices and hospitals directly with consumers.

In addition, MHI will support a multi-stakeholder initiative aimed at better understanding potentially-avoidable emergency department utilization, and develop strategies to support patients in accessing high-value primary care.

# MN Community Measurement (MNCM)



## History

In 2000, healthcare stakeholders in Minnesota were challenged to collect comparable data across health systems and make the results transparent by reporting it publicly. The medical directors of the health plans believed that they should work together to create a single, combined report that compared patient care and outcomes statewide – quality comparisons that remained aspirational to that point.

In 2002, the Minnesota Council of Health Plans launched the Minnesota Community Measurement (MNCM) project to put this idea into action, with a mission to accelerate health improvement by publicly reporting healthcare information. By 2005, MNCM became a non-profit 501(c)(3) with a board of directors that includes physicians, hospitals, health plans, consumers, employers, and professional associations. As a neutral, community-wide convener, MNCM brings together stakeholders to develop, collect, aggregate, and publicly report information. MNCM operates on revenue from a variety of funding sources, including government and non-government contracts, member dues and contributions, grants, and fee-for-service.

## Leadership

James Chase has served as president of MNCM since it was founded. John Fredrickh, MD, served as the original board chair, a position that is now held by Tim Hernandez, MD.

## Strategies

MNCM's work focuses on its core goals of measurement and reporting. They collaborate with a diverse set of stakeholders to reach consensus on what to measure, what to make transparent, and what to communicate, thereby creating trust and long-term partnerships within the community. The development and maintenance of measures also allows performance to be tracked year-over-year in a valid, reliable way. Stakeholders can use these measures in pay-for-performance programs, for quality improvements, and in accreditation programs.

## Services/Expertise

MNCM offers a range of services and custom solutions related to: testing and developing measures; collecting, analyzing, and reporting data and registry-like services; and offering customized and ad hoc services related to measurement and reporting of cost, quality, patient experience, and health equity.

During its initial year, MNCM produced its first performance report on optimal diabetes care, which used an innovative approach to reporting the five key components of diabetes care in one composite measure. That inaugural report allowed medical groups to see where they stood and to focus their quality improvement work. In 2004, MNCM publicly released the first "Health Care Quality Report," which featured comparative data on medical group performance on key measures. In 2007, MNCM led the nation with its "Health Care Disparities Report," which was created in partnership with the Minnesota Department of Human Services. The report compared primary care performance data results for patients insured by Minnesota Health Care Programs (such as Medicaid) to patients with commercial insurance on eight measures.

MNCM speaks about the various aspects of measurement and reporting at roughly 50 venues and conferences annually, which include graduate schools, provider groups, societies, and community organizations. In addition, MNMCM holds a one-day annual seminar with over 300 attendees, educating them on a variety of topics on healthcare measurement and reporting.

“All RHCs are pioneering new approaches to drive improvement in the healthcare system. NRHI helps us learn from each other about what strategies work best, and shorten implementation time by adopting what has already been shown to be successful in other regions.”

Jim Chase, President,  
MN Community Measurement

By publicly reporting results on the full breadth of MNMCM’s mission – quality, patient experience, cost, and equity – patients engage more readily with their care and clinics can make more informed decisions about where to focus quality improvement efforts. MNMCM provides resources to help patients build positive relationships with their providers, identify patterns with their provider by tracking information on their chronic conditions, and stay healthy with in-depth patient education on diabetes, depression, and more. Patients can find unbiased, trustworthy information on the quality of medical clinics, the experience they can expect to have as a patient, and the variation of the cost of health care on MNMCM’s consumer-focused website MNHealthScores.org.

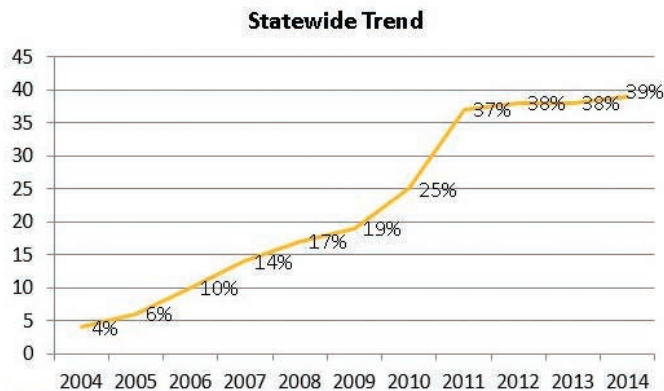
MNCM has been part of the Minnesota Statewide Quality Reporting and Measurement System since 2009. In addition, MNMCM provides data and analysis for the Minnesota Department of Health, and assists the local employer coalition with pay-for-performance programs.

### Networks/Partnerships

Prior to MNMCM’s formation, the health plans and providers measured quality and other metrics differently. Agreement within the community on over 70 measures that are aligned across payers and providers has improved transparency and catalyzed improvement. MNMCM provides administrative efficiency in the community by establishing a process that allows for all providers and health plans to submit data to MNMCM.

MNCM’s Measurement and Reporting Committee (MARC) recommends measurement priorities and specifications to the board, guiding principles or policies for public reporting of measure results, and tests ideas and strategies related to data collection. MARC’s

## Optimal Diabetes Care



Just 4% of patients with diabetes were optimally managed according to the first report to medical groups. In 2014, that number was up to 39%.

\* Underwent a measure specification change in 2015

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monthly meetings include physicians and other clinicians, health plans, technical specialists, and a consumer representative.

Throughout its history, MNCM has established partnerships with many RHICs through various projects and grants. Most recently, the organization partnered with RHICs on the Doctor Project, the Total Cost of Care pilot, the Center for Healthcare Transparency grant, and NRHI’s Support and Alignment Network.

### Major Accomplishments

MNCM provides medical groups with the detailed information that they need to move the needle on healthcare efficiency and cost. Major accomplishments that align with these efforts include:

- Development of the MNCM Direct Data Submission (DDS) Process – DDS is a secure, online process and infrastructure for medical groups to submit data from their medical records to MNCM. Data from medical records is more timely, reflects the care for all patients (including the uninsured), and can be reported by clinic site. Multiple clinics voluntarily participated by submitting data directly to MNCM for the optimal diabetes care measure. The results demonstrated variation in diabetes care even among practices within the same medical group, deepening the medical groups’ ability to target quality improvement efforts.
- Driving transparency in health care – MNCM currently collects and publicly reports on more than 70 measures that span the Triple Aim continuum, with several more in development
- Launching the nation’s first Total Cost of Care (TCOC) measure – More than 40 stakeholders worked for three years to develop, test, and validate the measurement process and its results. The four largest health plans in Minnesota gathered data from approximately 1.5 million patients for the measure, which was first publicly reported in the last quarter of 2014.
- Pioneering REL Data Collection – In 2008, MNCM worked with the community to begin collecting and validating race, Hispanic ethnicity, preferred language, and country of origin (REL) data. In 2015, MNCM released the nation’s first “Health Equity of Care Report,” which featured health outcomes related to optimal diabetes care, optimal vascular care, optimal asthma care for adults and children, and colorectal cancer screening. In 2016, MNCM released an updated report with four new patient experience measures segmented by race and Hispanic ethnicity, as well as comparable medical group reporting of the five quality measures included in the previous year’s report. Today, 98% of medical groups are reporting REL data.

### Why Join NRHI

Believing in the power of local initiatives, MNCM has been a part of NRHI since its inception.

Jim Chase, MNCM’s president, is an NRHI board member. MNCM has been involved in numerous collaborative efforts with other NRHI members, contributing to ongoing knowledge sharing.

### The Future

MNCM is excited to continue pushing the envelope into new measurement and reporting around cost utilization, specialty care, and patient-reported outcomes. Additionally, the organization will focus on achieving stakeholder alignment, and impacting the national transparency landscape.



## The Health Collaborative



### History

The Greater Cincinnati Health Council was formed in 1957 as a trusted voice on healthcare issues for health systems, hospitals, long-term care facilities, and business partners. In 1992, a multi-stakeholder-convening organization, the Health Collaborative, was established to deliver cross-sector solutions and health improvement projects to the region. Another organization, HealthBridge, was created five years later as a multi-stakeholder, non-profit corporation to ensure the secure exchange of regional health data.

In 2015, the Health Collaborative, the Greater Cincinnati Health Council, and HealthBridge merged into a single organization – The Health Collaborative – to align services and achieve a shared vision for better health, quality patient experience and outcomes, and lower costs. The Health Collaborative fosters community health through innovation, integration, and informatics.

Today, The Health Collaborative serves as the community's neutral forum for all stakeholders invested in the triple aim: better care, smarter spending, and healthier people. Its multi-stakeholder board includes representation from health systems, commercial insurance, business, public health, the community, and philanthropic agencies. The Health Collaborative functions as both a member organization with a dues structure, as well as a health information exchange with a subscription revenue model. Additionally, The Health Collaborative serves a multi-stakeholder convening function which is poised for grant and community funding.

### Leadership

The Health Collaborative is led by CEO Craig Brammer, with an executive team that includes Chief Medical Officer Richard Shonk, MD, PhD; CFO and Senior VP of Business Development Keith Hepp; Chief Administrative Officer Colleen O'Toole; Senior VP of External Relations Laura Randall; Senior VP of Informatics Jason Buckner; and Medical Director Barbara Tobias, MD.

### Strategies

The Health Collaborative's work is founded upon its four pillars: collective impact, program management, professional services, and innovation. Through these important areas, The Health Collaborative provides insight into regional health issues with data and value-added solutions, manages large-scale improvement initiatives, supports and accelerates innovation with partners, recognizes regional leadership, and promotes transparency and accountability.

Recognizing the business community's role in the regional healthcare landscape, The Health Collaborative engages employers and policymakers in important discussions. The Health Collaborative convenes an Employer Council comprised of regional business leaders, and also provides opportunities for employers to sit at the table with healthcare providers and consumers through the Collective Impact on Health initiative.

### Services/Expertise

The Health Collaborative delivers solutions to members related to quality improvement, healthcare payment reform, data transparency (through its consumer-facing public

reporting site, Yourhealthmatters.org), and regional disaster and emergency readiness resources. Its HealthBridge service line supports the health information exchange and provides technology solutions to care providers, ensuring patients and their healthcare providers have the right information, at the right time, to make decisions about the best possible care.

The Health Collaborative provides ongoing training and continuing educational credit unit opportunities for the region’s healthcare workforce, including classes on Meaningful Use and payment reform, as well as hands-on classes for nurses and disaster preparedness professionals. Additionally, the organization coordinates a high school program, called TAP MD, to help exceptionally talented high school students “tap” into their potential to fulfill careers in medicine. TAP MD takes high school juniors from the region into area hospitals and other medical facilities to observe first-hand what it’s like to work in the medical field.

Several of The Health Collaborative’s staff members serve on external committees to help inform decision-making at the state and federal levels. Dr. Shonk is a member of the Governor’s Task Force in Ohio for Patient Centered Medical Home. He is a founding member of the Ohio Patient Safety Institute and served as chairman of its board. Dr. Shonk currently sits on the statewide Patient Safety Organization Task Force. Hepp sits on the Strategic Health Information Exchange Collaborative Board, while Brammer sits on NRHI’s Board. Dr. Tobias serves on a number of committees, including the Health Policy Institute of Ohio Workforce Work Group, National Advisory Council Nurse Education and Practice, Health Resources Service Administration, American Academy of Family Physicians, Ohio Academy Family Physicians, and the Practice Transformation Steering Committee.



**Networks/Partnerships**

Nationally, the American Hospital Association, NRHI, and the Center for Healthcare Transparency have been key networks for The Health Collaborative. The organization is also a member of the Strategic Health Information Exchange Collaborative.

On the state level, The Health Collaborative is actively engaged with the Health Policy Institute of Ohio, Ohio Hospital Association, and the Governor’s Office of Health Transformation. As an established HIE, The Health Collaborative recently formed a partnership with Indiana’s HIE to seamlessly transfer patient data across state lines – a major step toward interoperability for the region.

Through its Collective Impact work, The Health Collaborative engages many local health advancement organizations including Interact for Health, Closing the Health Gap, Skyward, and the United Way, as well as regional health plans and every major health system in Greater Cincinnati. In 2015, The Health Collaborative partnered with a local start-up accelerator, Cintrifuse, to produce the region's first-ever Innovation XChange: Health Edition, bringing together national healthcare startups and key decision-makers across Cincinnati's healthcare providers to help address some of health care's most vexing problems.

The Health Collaborative has aligned with Minnesota Community Measurement, which served as a model, guide, and inspiration for public reporting efforts, particularly for clinical metrics on diabetes care.

### **Major Accomplishments**

#### *Comprehensive Primary Care (CPC) Initiative*

The Health Collaborative was instrumental in bringing to Cincinnati the CPC initiative, a Center for Medicare and Medicaid Innovation-funded initiative which has served as a catalyst for data aggregation, public reporting, practice transformation, and quality improvement.

Through The Health Collaborative's work related to education, dissemination of learnings and best practices, and stakeholder convening, 75 participating practices have realized approximately \$30 million in new care management revenue per year, and are well positioned to obtain shared savings dollars in 2016. The CPC practices in the Greater Cincinnati/Dayton region earned national recognition, ranking second out of seven CPC regions in the initiative. The Health Collaborative has been recognized by Ohio's State Innovation Model (SIM) as a model for state-wide innovation, thus giving the local health systems an advanced position to expand this payment methodology among their other practices. The Health Collaborative has positioned practice leaders within the CPC initiative as subject matter experts to help build the foundation and inform this model going forward.

#### *QI-Transitions of Care*

In partnership with the Council on Aging, the Health Collaborative launched the QI-Transitions of Care program, which has 13,277 participants from nine hospitals. As of spring 2016, the program has cut the 30-day readmission rate for participants by 30%.

#### *Collective Impact on Health initiative*

In 2014, The Health Collaborative became the backbone organization for Greater Cincinnati's Collective Impact on Health initiative. The Health Collaborative convened a multi-stakeholder steering committee featuring a broad spectrum of community leaders: nonprofit organizations, providers, health plans, and employers. This group is working to build consensus on health improvement priorities for Greater Cincinnati and Northern Kentucky. In support of this initiative, The Health Collaborative has hosted multiple leadership forums to engage over 100 community leaders, and has convened three action teams to identify strategies that will advance the health and health care of the community.

#### *Regional Epic Services (Electronic Health Records)*

The Health Collaborative convened Regional Epic Advisory Group members to drive value for members and direct regional strategy. The advisory group represents nine health systems and 30 hospitals from the Greater Cincinnati and Dayton areas.

Over 140 representatives came together to learn, share, and network about their Epic solutions and best practices at the first annual Epic Regional User Conference. The Health Collaborative has launched five new special interest groups to enable members to share tangible solutions to enhance their respective Epic systems.

#### *Advance Care Planning (ACP) Coalition*

The Health Collaborative's first Advance Care Planning Coalition engaged 19 hospitals and post-acute care members, who came together to create community-wide engagement and ensure that eligible patients have the opportunity to express their wishes and goals for end-of-life care – and to have those wishes honored. Through the coalition's work, over 500 ACP conversations were conducted, more than 150 ACP plans were documented, and over 80 ACP facilitators were trained.

The Health Collaborative also partnered with the Hospice of Cincinnati on ACP initiatives, which resulted in an additional 355 trained facilitators and 176 trained providers. These efforts led to the development of EHR enhancements and process changes, including best practice alerts, to ensure more patients, families, and providers engage in end-of-life conversations.

#### *Innovation*

The Health Collaborative supports and accelerates data sharing to ensure that patients get the right care, at the right time. Currently, 9,000 physicians are connected and active through the HealthBridge service line, with 15 million electronic messages flowing through the line monthly and roughly 467,000 patients monitored for event notifications. The Health Collaborative established an inter-state HIE partnership with Indiana to follow the footprint of patients through the digital exchange of information across communities, states, and technology systems.

#### **Why Join NRHI**

The Health Collaborative recognizes the value of multiplying its accomplishments, and dividing its challenges with other communities working toward similar objectives. NRHI provides an excellent vehicle to accomplish those goals through the network's policy guidance, technical assistance on projects, and opportunities to interface with other population health-oriented communities.

#### **The Future**

The Health Collaborative will focus more on data transparency initiatives to help the community make data-driven decisions that enhance population health, while reducing the overall cost of care. To do this, the organization will continue along the path that it has charted with the CPC initiative and its aggregation of health plan (both government and private) claims data to provide the connection between quality and cost for specific populations. As a Qualified Entity, The Health Collaborative will take further steps in 2016 toward becoming a credible data repository for the federal government.

The Health Collaborative also continues its work on a local planning grant from Bethesda, Inc. to explore the feasibility of designing and implementing a community Triple Aim dashboard. Similarly, The Health Collaborative has been awarded a Total Cost of Care (TCOC) grant from NRHI to identify and address regional barriers to reporting a TCOC measure and best practices for sharing cost information with key community stakeholders.

## Wisconsin Collaborative for Healthcare Quality (WCHQ)



### History

In the late 1990s and early 2000s, national healthcare organizations and health insurers had developed standards of care based on their specific objectives and purposes. For Wisconsin healthcare providers, however, that data had limited value. It reflected an assortment of metrics that often failed to acknowledge clinical best practice and local care improvements. Wisconsin's healthcare community was ready for something more meaningful, more useful, and more relevant for improving care, reducing cost, and delivering value. And importantly, state healthcare providers wanted something that they had developed through consensus.

To realize this goal, a group of visionary healthcare leaders and the business community came together to explore how they could measure performance. Each health provider group invited a business leader from its own area to join the discussion. Gradually, the group understood what needed to happen to create value in health care and moved on to the next big hurdle in the process: deciding what data to collect and how to report it.

A dedicated group was charged with determining what the collaborative would measure, how they would measure it, and how they would report it. After months of intense meetings, the foundation was built, the initial set of measures was selected, and the Wisconsin Collaborative for Healthcare Quality (WCHQ) was born. WCHQ publicly reports and brings meaning to performance measurement information that improves the quality and affordability of health care in Wisconsin, in turn improving the health of individuals and communities. WCHQ's primary sources of funding include membership dues, grant-funded projects, and sponsorship revenue.

### Leadership

The original WCHQ staff leaders were Executive Director Debra Unger, as well as Michael Barbouche and Betsy Clough. The current staff leaders are President and Chief Executive Officer Christopher Queram, and Chief Operating Officer Theresa Mees.

### Strategies

WCHQ's multi-stakeholder board of directors strategizes around four major objectives: strategic growth, membership engagement, operational excellence, and fiscal sustainability.

In addition to the four major objectives, WCHQ actively employs the following strategies:

- Staying informed on national, state, and regional initiatives, including CMS' efforts related to provider quality, measurement, and new payment models
- Establishing strong working relationships with partners and stakeholders at the state and national levels
- Aligning WCHQ's work with NRHI's strategic objectives
- Participating actively in NRHI, National Quality Forum (NQF), and national, state, and regional committees and work groups



## Services/Expertise

WCHQ provides a range of services, including internal membership benchmarking, as well as public reporting and benchmarking reports at the organization and site level. WCHQ also offers bi-monthly Assembly meetings, performance improvement opportunities (including site visits, webinars, and an annual statewide performance improvement event), technical assistance with data, and toolkits for best practices in screening for diabetes, high blood pressure, and colorectal cancer.

WCHQ staff members regularly share their knowledge with other collaborative members as well as students, fellows, and stakeholders. Many of WCHQ's lessons learned have been published in *Health Affairs*, demonstrating widespread value. WCHQ staff members also serve on national and regional committees and task forces where important strategies are being developed to improve care, lower costs, and provide better access for patients.

“Shortly after I arrived at WCHQ in 2005, I was invited to join a small group of leaders from the most active regional collaboratives then in existence. It didn't take long for us all to recognize the potential in creating a formal network to bring together organizations and individuals that are kindred spirits pursuing missions that are, at once, quixotic yet stunningly vital to the people and communities they serve. And, while each collaborative reflects the unique characteristics of its region, there is indisputable power in the willingness to share freely with each other the collective knowledge, experience, wisdom, and moral support as we each seek to demonstrate that our visions are achievable. That is, and remains, the essence of NRHI.”

Chris Queram, President and CEO,  
Wisconsin Collaborative for Healthcare  
Quality (WCHQ)

## Networks/Partnerships

WCHQ cultivates relationships with partners who share the organization's passion for organizational change, both locally and nationally. For example, WCHQ works closely with the Medical College of Wisconsin and the University of Wisconsin on health-related issues. In addition, WCHQ and Minnesota Community Measurement have exchanged knowledge and experiences related to measurement and patient experience, and have partnered on CMS initiatives and grant applications.

WCHQ has also partnered with RHCs in Massachusetts, Maine, and California, among others, on Consumer Reports projects (including *Choosing Wisely*<sup>®</sup> and initiatives related to RWJF's Aligning Forces for Quality grant).

### **Major Accomplishments**

WCHQ began reporting quality metrics in print in 2002, moved to online, system-level reporting in 2003, and began reporting at the clinic level in 2014. The organization was designated as a Qualified Clinical Data Registry in 2014, and has also created a data management company (called Physician Compass) in partnership with the Wisconsin Hospital Association. Originally founded with six participants, WCHQ is now approaching 40 members.

### **Why Join NRHI**

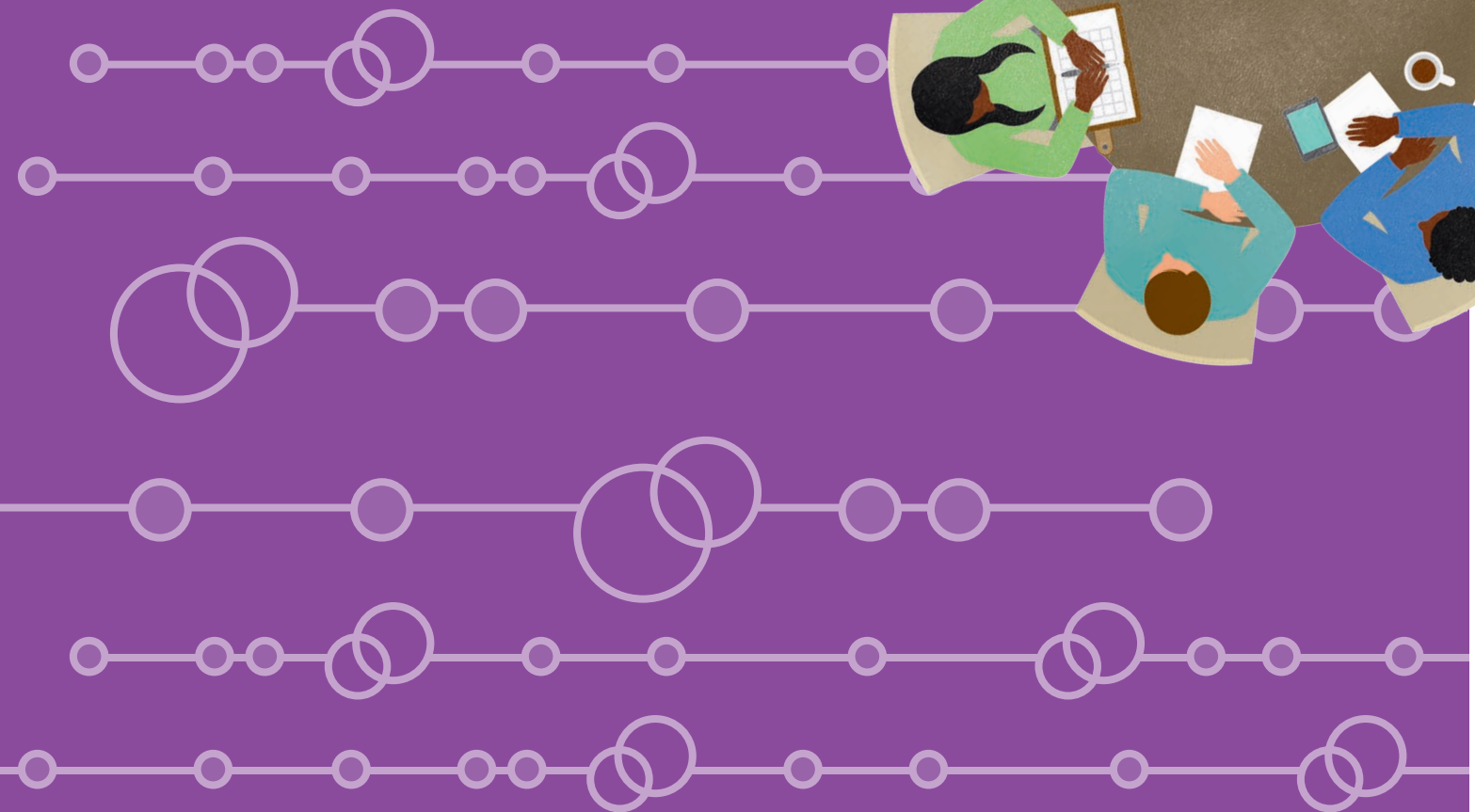
A founding member of NRHI, WCHQ advocated for the creation of an organization to promote learning and sharing among regional health improvement collaboratives, as well as to advocate on their behalf with the private and public sectors at the national level. NRHI serves as a vehicle for RHICs to thrive as agents for transformational healthcare change within their local communities.

### **The Future**

Moving forward, WCHQ will continue to grow its membership, produce public reports at the physician level, and work with providers to ensure that they are getting maximum value out of their data tracking and analysis initiatives.

WCHQ also plans to continue existing efforts that will move the needle on safety, reliability, and efficiency while lowering healthcare costs. The organization will continue to work with their partner organizations, the Wisconsin Hospital Association (WHA), the Wisconsin Health Information Organization (WHIO), the Wisconsin Medical Society, and the Wisconsin Statewide Health Information Network (WISHIN) on cost and efficiency efforts.

# Region: South



## Kentuckiana Health Collaborative (KHC)



### History

In 2001, the United Auto Workers and Ford Motor Company launched a Community Healthcare Initiative in the Louisville area to improve the health status and healthcare delivery system. The Lewin Group conducted a comprehensive health needs assessment of the community and presented findings through forums, which led to the creation of a coalition to work on high-priority issues. These efforts resulted in the formation of the Kentuckiana Health Alliance in early 2003. The name changed to the Kentuckiana Health Collaborative (KHC) in 2011 when it became a 501(c)(3).

KHC is a multi-stakeholder collaborative of businesses, multi-employer trust plans, health providers, health plans, physicians, health systems, pharmaceutical companies, academic institutions, and non-profit health groups. KHC serves as a catalyst to transform health care by aligning providers and delivery systems, health plans, businesses, and other key healthcare stakeholders in systemic improvement efforts to drive better care, better value, improved experience, and improved community health.

KHC initially focused on issues related to tobacco, obesity, and chronic disease. Its first tobacco-related projects focused on policy issues and youth smoking prevalence through the use of social norms in marketing campaigns. KHC's second project focused on obesity and chronic disease in the workplace by providing measurable objectives, learning, coaching, and grant funding for employers to develop comprehensive worksite wellness programs. To build on this effort, KHC created the "Kentuckiana Metro on the Move" web-based physical activity and weight loss tracking system to allow organizations, teams, and individuals to participate in customized and public challenges. KHC has more recently prioritized improving healthcare quality and reducing costs.

### Leadership

Leslie Patterson and Mary Lyle were a part of KHC's initial leadership team. Currently, Randa Deaton and Teresa Coutts lead KHC.

### Strategies

KHC is open to all community members, and works as a neutral convener for solving complex local healthcare problems through consensus-based decision-making. KHC works to maximize local resources by aligning collaborative partners and minimizing duplication.

### Services/Expertise

KHC publishes quality and location information on primary care practices, women's health practices, and hospitals in Greater Louisville at [www.gohealthshare.com](http://www.gohealthshare.com). Making trusted healthcare quality data and education available for the public helps patients make informed decisions about the care they receive. KHC offers several educational and networking events that focus on learning and discussing emerging trends in health care through free quarterly health forums, an annual conference, and employer-only roundtables.

KHC also combines commercial and Medicaid health plans data to provide quality measurement reports to 4,500 clinicians and 160 group practices in Kentucky and Southern Indiana. Improving rates of evidence-based medicine through measurement impacts the entire community.

KHC serves on Kentucky's State Innovation Model (SIM) Advisory Board, Kentucky Health Data Trust, and many outside committees, including Humana's Louisville Health Advisory Board, Baptist's Kentucky Health Taskforce, Colorectal Cancer Steering Committee, KentuckyOne's Accountable Health Communities, and Asthma Friendly Louisville. KHC often meets with employers to discuss the local health landscape and share best practices.

### **Networks/Partnerships**

For a decade, KHC has been the only organization measuring the quality of primary care providers in Kentucky and Southern Indiana. KHC created widely-accepted abbreviated, evidence-based clinical guidelines on diabetes, acute low back pain, and adult cancer screening, with consensus from health systems, plans, and the medical society. KHC provides the only quality data accessible to the general public on primary care and women's healthcare providers in Kentucky and Indiana.

### **Major Accomplishments**

In 2014, KHC brought together key employers, hospital systems, health plans, physicians, public health, government, and community leaders to develop the Greater Louisville Healthcare Transformation Plan. The group created a shared vision to improve the quality of care and population health, reduce cost trends, and improve the experience for patients and their healthcare teams in the Greater Louisville area.

KHC also developed the GoHealthShare website, which was built on nearly a decade of collaboration by many dedicated healthcare experts and clinicians representing over 60 local organizations, with 90% provider participation in this voluntary public reporting effort. Using the KHC individual reports in partnership with the Greater Louisville Medical Society, KHC moved the number of National Committee for Quality Assurance (NCQA) Diabetes Recognition Program (DRP)-certified doctors from 25 to 140, and HbA1c testing from 81% in 2005 to 92% in 2015.

### **Why Join NRHI**

KHC joined NRHI in 2015 and has found the networking, learning opportunities, affinity groups, and policy updates to be extremely valuable.

### **The Future**

KHC has been primarily funded by purchasers such as the United Auto Workers, Ford, and GE, as well as by membership dues, public and private grants, and conference funding. Moving forward, KHC would like to align the provider community with more meaningful quality, cost, and experience measurement. The goal would be for this measurement to be publicly displayed, where appropriate, and aligned to alternative payment models.



## Louisiana Health Care Quality Forum (Quality Forum)



### History

Hurricanes Katrina and Rita resulted in merciless devastation along the Louisiana coastal region in 2005. Amid the challenge of rebuilding entire communities came the opportunity to create a more cost-effective, quality-focused, and technologically advanced healthcare system.

In 2006, the Louisiana Health Care Redesign Collaborative – comprised of providers, payers, patients, and consumers – recommended creating a private, non-profit organization that would unite these stakeholder groups to effect statewide change across the care delivery system. Based on this recommendation, the Louisiana legislature recognized the Louisiana Health Care Quality Forum (Quality Forum) in 2007. The Quality Forum is dedicated to leading evidence-based, collaborative initiatives to reshape health care in Louisiana to be patient-centered, technologically advanced, and value-driven. Originally state-funded, the Quality Forum has since diversified its revenue stream to include federal, state, private, and grant funding.

### Leadership

Shannon Robshaw served as the Quality Forum's first executive director. Currently, the organization is led by Cindy Munn, who joined the Quality Forum in 2010. Family medicine physician Michael O. Fleming, MD, served as the first board president.

The Quality Forum was formed as a multi-stakeholder effort, governed by a board of directors that represents healthcare providers, payers, purchasers, and consumers. Stakeholders are viewed as essential and equal partners working together to identify, develop, and implement the tools, resources, and programs necessary to drive quality improvement in care delivery, outcomes, access, and costs across Louisiana.

### Strategies

Designed and positioned as a neutral convener from its inception, the Quality Forum's key strategy hinges on its ability to bring together Louisiana's healthcare stakeholders to plan, facilitate, and coordinate activities that advance healthcare quality and value.

### Services/Expertise

The Quality Forum's major areas of focus include health information technology (IT), patient-centered care and practice transformation, quality measurement and analytics, end-of-life care planning, and education/outreach.

By supporting providers and entities across the healthcare spectrum in complying with new state and federal guidelines, and regulations that are part of the ever-changing healthcare landscape, the Quality Forum has demonstrated great value to the state, its partnering organizations, and Louisiana's residents.

The Quality Forum administers the statewide Health Care Consumer Advisory Council to serve as the voice of Louisiana's healthcare consumers. Comprised of representatives from consumer-facing organizations from across Louisiana, the Council helps to develop statewide strategies focused on educating and empowering patients and families on using health IT to better manage their care.



## Working Together For A Healthier State

The Quality Forum’s staff members are regarded as content experts and regularly share their insights at the local, state, regional, and national levels. They keep government and business interests informed through on-site conferences and seminars, virtual education sessions, speaking engagements, media interviews, individual consultations, and informational materials.

Organizational leaders also serve on committees and boards of government- and business-focused organizations, such as the Texas/Louisiana Telehealth Resource Center, Louisiana Association of Business and Industry’s Health Care Council, Gulf Coast Chapter/HIMSS, and the Louisiana Business Group on Health. The Quality Forum also serves as a key resource to the Louisiana Department of Health and Hospitals (DHH) and its Medicaid program.

### Networks/Partnerships

With its collaborative spirit, the Quality Forum partners with the Louisiana DHH to support and advance the state’s healthcare strategy and initiatives. The Quality Forum has also developed partnerships with organizations beyond the Louisiana state borders, including:

- The Oregon Health Care Corporation, which has provided valuable guidance regarding the Qualified Entity Certification for Medicare Data Program, and continues to serve as a key resource as the Quality Forum explores program requirements and criteria
- The Pittsburgh Regional Health Initiative and the Jewish Healthcare Foundation (PRHI’s parent organization), both of which have shared valuable information about their end-of-life initiative (Closure). Those learnings allowed the Quality Forum to broaden and expand its own Louisiana Physician Orders for Scope of Treatment (LaPOST) program.
- The Wisconsin Collaborative for Healthcare Quality, which provided beneficial suggestions for partnering with health-related professional associations
- Maine Quality Counts, which shared insights regarding the importance of actionable healthcare data analytics for employers

### Major Accomplishments

As the state-designated entity to lead the planning and implementation of health IT grants, the Quality Forum convened more than 60 key stakeholders in 2010 to develop a strategic operational health information exchange (HIE) plan for Louisiana. The resulting plan positioned the Quality Forum to receive nearly \$18 million in federal grant funding to initiate a regional extension center (REC) and the statewide HIE. The HIE launched in 2011 and currently includes more than 300 providers, hospitals, health systems, clinics, home health agencies, school-based health centers, ambulance providers, and other health-related entities, with more than 190 participants exchanging data. As of February 2015, the HIE houses more than 4.3 million unique patient records and processes nearly 91 million transactions per month. It has been recognized as one of the country’s most advanced HIEs.

Since 2010, the Louisiana REC has helped more than 2,000 healthcare providers and 41 hospitals to adopt, implement, and meaningfully use EHRs, and was the seventh REC in the country to reach its grant goals. With this support, providers and hospitals have received nearly \$118 million in Medicare/Medicaid EHR incentive payments. The Quality Forum's services have evolved to include HIE integration, patient-centric care model transformation, and provider education. The Quality Forum also partners with national companies to provide practice transformation services to physicians as part of accountable care organization (ACO) development.

The Quality Forum partnered with the Louisiana DHH in August 2015 to lead a statewide, direct-to-consumer campaign entitled, "Your Health in Your Hands." It is designed to promote the use of health IT by Louisiana patients and families for improved decision-making, better outcomes, and a greater patient experience while providing education about patient rights, including how to get and use copies of personal health information. The campaign positions Louisiana as one of the first states in the nation to launch such an ambitious initiative.

The Quality Forum's impact on patients, providers, and office staff is exemplified through its health IT accomplishments. By using the patient portal that is available through the statewide HIE, patients can now access digital copies of their health history, communicate directly with providers through the secure messaging of the HIE, and experience fewer repeated tests. Office staff experience reduced call volume and spend less time searching for paper charts. Connected physicians can quickly and securely access patients' medical histories, test results, and prescriptions.

The Quality Forum oversees other patient-centered initiatives, including the LaPOST Coalition, which convenes frequently to discuss advance care planning education efforts in the state for healthcare professionals and consumers. LaPOST is a document designed to improve end-of-life planning for Louisiana patients with serious, advanced illnesses. The Coalition includes physicians, nurses, first responders, nursing homes, social workers, lawyers, health systems, and hospice agencies, among others. With a grassroots approach, the LaPOST initiative has expanded since 2010 to provide virtual, in-person, and remote education and training in advance care planning and end-of-life conversations to thousands of healthcare providers, organizations, patients, and families. The Quality Forum is exploring the development of an electronic registry for this initiative.

### **Why Join NRHI**

As an NRHI member since 2009, the Quality Forum has benefitted from networking with "kindred spirits" who are committed to improving healthcare quality and value in different ways and in different parts of the country. The ability to share best practices, lessons learned, and challenges with like-minded, multi-stakeholder organizations is invaluable. The Quality Forum looks forward to NRHI's continued organizational growth, and supports its efforts to work closely with federal agencies as well as national foundations and stakeholder groups to transform healthcare delivery, payment and information systems.

### **The Future**

The Quality Forum aims to expand the use of health IT in behavioral health, Medicaid specialty areas, and long-term care to improve patient health outcomes, as well as transitions of care. The organization is also focused on increasing provider participation in Louisiana's HIE, promoting the use of exchange-related services, and developing the IT infrastructure necessary for Medicare Shared Savings Programs as well as ACOs.

# Region: West



## Community First, Inc.



### History

Community First, Inc. was founded in July 2014 after recognizing that it will take a community to shift the idea of health care from treating disease to caring for health. East Hawaii, on Hawaii Island, has a uniquely strong sense of community and Community First provides a neutral forum for healthcare stakeholders to come together, clear up past grievances, and develop solutions that are in the community's interest. It is led by Barry Taniguchi, an iconic community leader and CEO of a local supermarket chain who has realized that the healthcare cost crisis is more of a business problem than a clinical one, and that the medical system alone cannot meaningfully address it in East Hawaii.

### Leadership

Community First is staffed by two volunteers: Executive Director Mike Sayama and Community Engagement Coordinator Anthony Kent. Its board of directors includes: Barry Taniguchi, CEO and Chairman, KTA Superstores (President); Dr. Richard Lee-Ching, Managing Director, East Hawaii Independent Physicians Association (Vice-President); Roberta Chu, Senior Vice-President, Bank of Hawaii (Treasurer); Ka'iu Kimura, Executive Director, Imiloa Astronomy Center (Secretary); Dan Brinkman, CEO, Hilo Medical Center; Charlene Iboshi, Prosecuting Attorney (retired), County of Hawaii; and Mike Sayama, PhD., Vice-President, Pono Corporation (Executive Director).

### Strategies

Community First has two strategies:

- Grassroots initiatives to tip the paradigm of health care from treating disease to caring for health
- Promoting trust and collaboration among the healthcare providers, insurance plans, and employers through the Regional Health Improvement Collaborative so that they can transform the system through payment reform, information integration, care coordination, and community engagement

### Services/Expertise

Numerous Community First health initiatives provide valuable services to the community, including:

- The "Best Heart Care" initiative provides care coordination and care management for the most chronically ill patients in the community who then receive intensive attention and personalized support to improve their health and environment
- The "Recruit and Retain Physicians" initiative increases access to primary and specialty care, which are critical needs in East Hawaii
- "Ending High Blood Pressure" engages University of Hawaii nursing students to educate sixth graders, who in turn take the blood pressure readings of adults in their homes. The goal is to foster healthier attitudes around controlling hypertension for children, and motivate adults to begin managing their blood pressure.
- The "East Hawaii Choices" initiative educates the community on the importance of documenting desires for end-of-life care and communicating those plans to their families and PCPs



Community First also highlights healthcare challenges, promotes healthy living, and makes calls to action for community members to take responsibility for their own well-being.

### **Networks/Partnerships**

Community First has played a pivotal role in cultivating valuable relationships among hospitals, private physicians, health plans, and businesses to recruit new physicians in the community. Similarly, Community First unified non-integrated providers to collaborate and develop the “Best Heart Care” initiative, which brought key providers together to design a continuum of care for chronically ill patients.

### **Major Accomplishments**

Community First’s ability to leverage relationships among health plans, physicians, and others has yielded results in numerous ways:

- Community First, in partnership with the Hawaii Island Chamber of Commerce, held an event in 2015 that was attended by 85 professionals from the healthcare, business, and education sectors. The event served to motivate the community into action by presenting healthcare cost trends, actual cost data, and accountable payment models.
- The “Best Heart Care” initiative provides the continuum of care necessary to deliver the best heart care in east Hawaii, including collaboration with non-integrated providers involved with patient care through the creation of new (and the modification of existing) forms, procedures, and protocols. Through the initiative, Community First will collect data on healthcare costs, hospital admissions/readmissions, emergency department utilization, and patient satisfaction. The results will inform future efforts to manage additional chronic diseases.
- To address staffing concerns for the critical care needs in East Hawaii, Community First created and contributed \$260,000 to a new physician subsidy program.

### **Why Join NRHI**

Community First joined NRHI in December 2015 to connect with other RHICs as Community First moves toward an accountable payment model in East Hawaii. Community First has already benefited from the network of contacts, reaching out to several groups and receiving valuable information about tactics for contacting hospitals and private physicians, as well as resources from others who have moved into a new payment model.

### **The Future**

Community First is dedicated to realizing a community which believes health care is caring for health and not just treating disease, and where every resident is supported in taking responsibility for their health and well-being by medical providers, employers, and their county.

### History

HealthInsight was founded as a Professional Standards Review Organization (PSRO) in 1970 when the organization was tasked with improving the quality and efficiency of services delivered to Medicare beneficiaries. HealthInsight initially performed peer review work as an affiliate of the Utah Medical Association and expanded service into Nevada in the 1980s. The PSRO program later was reinvented to become the Medicare Quality Improvement Organization (QIO) program.

By the mid-1990s, HealthInsight's formal affiliation with the medical society ended, and the organization expanded its agenda to include value-oriented work. HealthInsight serves as a primary agent in focusing community energy to achieve significant, continuous improvement in population health, as well as healthcare quality and effectiveness in Utah, Nevada, and New Mexico.

### Leadership

HealthInsight is led by President and CEO Marc Bennett, Senior VP of Medical Affairs Jerry Reeves, MD, and Medical Director Sarah Woolsey, MD. HealthInsight has an effective, multi-state governance structure in place, with oversight provided by a management board featuring representatives from Nevada, New Mexico, and Utah. It also maintains a state board in each of those three states to maximize local participation, ownership, and impact. HealthInsight's boards feature four key stakeholder groups: providers (including physicians) and provider organizations, payer organizations, employers and other healthcare purchasers, and public entities, including patients or patient representatives, consumer representatives, and consumer advocacy organizations.

### Strategies

HealthInsight deploys a multi-faceted approach to move beyond gradual, incremental improvements and produce the major changes needed to achieve demonstratively better health outcomes at a lower cost. HealthInsight works toward these goals by supporting partners and fostering initiatives that move the following levers:

- Sharing clinical data across the continuum of care
- Making optimal use of health information technology to improve and coordinate care
- Promoting transparency of quality and cost data and continuously providing actionable data to frontline workers
- Redesigning work flow and care processes, and supporting associated culture change
- Engaging consumers of health care in owning their own care and their own health, enabled with cost and quality data

### **Services/Expertise**

HealthInsight has over 30 years of experience with providing services in process improvement, culture change, patient activation, workflow redesign, human factors analysis, electronic health record transition, office redesign, data analysis, privacy and security, physician practice transformation, Lean methodology, assisting with value-based purchasing programs, and developing innovative approaches to quality improvement.

### **Networks/Partnerships**

HealthInsight partners with county health districts, state health departments, health plans and employers in health fairs, community health centers, skilled nursing facilities, hospitals, pharmacies, churches, and other settings. These broad partnerships further crucial community health goals, such as increasing adult and child immunization rates; helping patients self-manage health conditions including high blood pressure, diabetes, and cholesterol; and quitting smoking and other tobacco-based products.

### **Major Accomplishments**

In 2008, the HealthInsight-led Nevada Partnership for Value-driven Health Care (NPV) and Utah Partnership for Value-driven Health Care (UPV) were both designated a Chartered Value Exchange by the Agency for Healthcare Research and Quality and U.S. Health and Human Services Secretary Michael Leavitt. In addition, HealthInsight was also awarded the Health Information Technology Regional Extension Center contracts for both Nevada and Utah in 2010, championing adoption and Meaningful Use of electronic health records.

### **Why Join NRHI**

HealthInsight joined NRHI to learn about broad-based community transformation models that extend beyond traditional QI efforts, and to partner with others who share its desire to change fundamental environmental factors such as payment systems, transparency, and patient engagement. HealthInsight has gained significant value from joining NRHI by learning from others, seeing different ways of operating, conducting peer visits, and forming partnerships with policy makers. HealthInsight identifies NRHI as the most innovative and active driver of community-level change.

### **Future**

As health care continues its evolution to reward quality and value and recognize the social determinants of health, HealthInsight will serve as an important convener and catalyst for community-wide solutions to community-wide problems.

## HealthInsight Nevada



### History

For more than 20 years, HealthInsight Nevada has been a neutral community convener. Starting in the 1990s, the organization brought together providers to improve care for stroke patients, increase pneumonia vaccination rates for hospitalized patients, and reduce the overutilization of blood products. Over time, the stakeholders that HealthInsight Nevada unites have expanded beyond providers to include payers, purchasers of care (employers), and patients. HealthInsight collaborates with these diverse groups to move the needle on safety, reliability, efficiency, and cost.

In 2005, HealthInsight implemented Web displays of rank-ordered national performance comparisons, which have been used as quality performance metrics in value-based contracts between employer plan sponsors and hospital systems. The performance comparisons also serve as the basis for the annual HealthInsight Quality Awards in Nevada for high-performing physician offices, hospitals, nursing homes, and home health agencies.

By 2011, HealthInsight established and began operating HealthIE Nevada, a statewide clinical health information exchange that connects electronic health records at hospitals, doctor offices, diagnostic facilities, imaging facilities, nursing facilities, and public health departments to improve coordination, continuity and communication of care throughout Nevada.

### Services/Expertise

HealthInsight Nevada educates and builds awareness among physicians and other healthcare professionals on preventing harm and involving patients in their own care, including by:

- Assisting with direct care of long-term nursing facility residents to prevent hospitalizations
- Providing HIE functionality to clinicians to improve care and increase care coordination
- Delivering provider group prenatal lessons that ease mothers' (and their support systems') concerns about pregnancy, and striving for better birth outcomes
- Instructing leaders of diabetes self-management education courses
- Hosting a Patient and Family Advisory Council to gain direct patient perspective, and apply that perspective to work that HealthInsight Nevada carries out
- Focusing on enhancing joy and resiliency in the workplace using Dr. Bryan Sexton's work, which has been shown to improve professional satisfaction

Educational efforts are an important part of HealthInsight Nevada's services. These efforts include providing a robust internship/externship program that has included undergraduate and graduate students from the University of Nevada, Las Vegas and the College of

Southern Nevada who are taking classes in public health and healthcare administration. In addition, HealthInsight Nevada includes local pharmacy students in health fairs and programs related to reducing adverse drug events, and serves as a clinical rotation site for an undergraduate nursing program at Roseman University of Health Sciences.

HealthInsight staff members regularly provide presentations and analysis to medical students and other health professionals to help them better understand issues and trends in health and healthcare delivery outcomes. Staff members also serve on a variety of outside committees, including one who is currently a member of the Nevada Division of Public and Behavioral Health's healthcare-associated infections (HAI) advisory group. The group is responsible for recommending policies, programs, and other needs related to HAI prevention and control to the division's office of Public Health Informatics and Epidemiology.



Collaborative Learning Session  
from October 2015

### **Networks/Partnerships**

HealthInsight holds leadership positions with multi-stakeholder collaboratives in Nevada, including the Southern Nevada Health District, the Washoe County Health District, and the Nevada State Department of Health. HealthInsight Nevada also has partnerships and projects with educational institutions, employer coalitions, government agencies, and healthcare provider associations. HealthInsight Nevada has actively partnered with the Pittsburgh Regional Health Initiative on integrating behavioral health services into primary care, by improving team-based care for patients who are at high risk for depression and alcohol misuse.

Other key partnerships include the Improving Diabetes and Obesity Outcomes Council (iDo), which was chartered 2008 in collaboration with HealthInsight as a statewide council that champions physical activity, healthy nutrition, diabetes prevention programs, diabetes self-management programs, and other evidence-based interventions throughout urban and rural Nevada. In 2011, HealthInsight Nevada joined the Department of Health and Human Services' Partnership for Patients Initiative, which aims to improve safety in hospitals by reducing healthcare-associated infections, early inductions of labor, pressure ulcers, obstetric adverse events, ventilator-associated pneumonia, readmissions, and injuries from falls.

### **Major Accomplishments**

HealthInsight Nevada's programs and initiatives have reduced the prevalence of early induction of labor, obstetric complications, falls, pressure ulcers, avoidable readmissions, healthcare-acquired infections. Those programs have also contributed to improved star ratings, patient satisfaction ratings, blood pressure control, diabetes control, and obesity rates. HealthInsight Nevada's efforts include:

- Implementing the Admissions and Transitions Optimization Program with 24 urban and rural long-term-care nursing facilities throughout Nevada in 2012. This Center for Medicare and Medicaid Innovation-funded program has reduced hospital transfers, hospital admissions, and total medical costs for enrolled beneficiaries, and has increased the number and proportion of beneficiaries who have signed advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms. The nursing facilities have increased their capabilities to safely and more appropriately manage changes in health status among their long-term residents.



- Convening the original task forces that developed and implemented the statewide health information exchange, which included representatives from Nevada's Department of Health and Human Services, Medicaid, hospital systems, payers, employers, physician group practices, and other key opinion leaders in the state
- Organizing and serving on the board for the Nevada Antimicrobial Stewardship Program, which has a mission to optimize antibiotic use, improve patient outcomes, and maximize resource utilization to decrease antibiotic resistance and adverse events
- Collaborating with the Nevada State Legislature to pass laws and regulations governing health information exchanges, community health workers, and telemedicine
- Collaborating with Nevada's Medicaid State Innovation Model, Anthem Blue Cross Blue Shield, the Nevada Primary Care Association, MGM Resorts International, and wellPORTAL to implement effective patient-centered medical homes that have achieved cost-savings, improved health scores, and improved chronic disease control measures

### **The Future**

HealthInsight Nevada will continue to focus community energy on creating a higher-quality, more inclusive, and more responsive health system for all stakeholders in Nevada.

# New Mexico Coalition for Healthcare Value



## History

The New Mexico Coalition for Healthcare Value (the Coalition) was formed in 2015 as an employer-led, multi-stakeholder transition organization at the conclusion of the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality (AF4Q) initiative. The RWJF-AF4Q grant provided a vehicle for local employers to drive change in the healthcare system by promoting value-based care and transparency. Recognizing the community-wide benefits of the collaborative, a group of organizations (including HealthInsight, which had been the umbrella organization for the RWJF-AF4Q grant) agreed to provide seed money for the Coalition.

## Leadership

Patricia Montoya has led the Coalition since it was formed, and she was also the staff leader for the duration of the AF4Q grant. The Coalition's oversight board consists of employer, health plan, and federally qualified health center representatives, as well as a representative from HealthInsight New Mexico.

## Strategies

The Coalition strives to be an innovative force for increasing the value of health care in New Mexico by aligning providers, consumers, and payers. Still in its infancy, the Coalition remains focused on membership recruitment.

## Services/Expertise

The Coalition is a leading voice in advancing healthcare data transparency and payment reform across the state. Before the Coalition's establishment, New Mexico lacked an organization dedicated to bringing people together to learn about and discuss public reporting, payment reform, transparency, and healthcare value.

In addition, the Coalition provides educational seminars to its members, patients, and other New Mexico employers on topic areas including IRS-employer required reporting under the Affordable Care Act and depression in the workplace.

## Networks/Partnerships

The Coalition has partnered with Consumer Reports on the *Choosing Wisely*<sup>®</sup> campaign, and has developed a microsite which is used by employers to reach out to their employees about the value of being informed healthcare consumers.



Coalition Planning Meeting from Spring 2015

### **Major Accomplishments**

Approaching its one-year anniversary as a post-AF4Q organization, the Coalition continues to grow its membership base, create a sustainable funding model, and gain recognition for its contributions to high-value care at the state level.

The organization's AF4Q payment reform summit informed and influenced New Mexico's Medicaid redesign efforts, and also laid the foundation for the first healthcare quality measures report, which was released in 2011.

### **Why Join NRHI**

The Coalition joined NRHI to be part of an organization of thought leaders working on healthcare transformation and transparency. The information and knowledge provided by NRHI has been invaluable to the Coalition's effort to grow and enhance New Mexico's population health.

### **The Future**

The Coalition wants to drive New Mexico's health plans, Medicaid, and provider systems toward standardized healthcare quality metrics. Since the state currently has no public reporting, the Coalition will continue to advocate for transparency regarding quality and costs, and for an all-payer claims database.

In order to continue these efforts, the Coalition is looking to expand its membership, and is exploring grant opportunities to assist with project funding.

## History

HealthInsight Utah works toward advancing transparency of healthcare quality, promoting adoption of health information technology, and aligning financial incentives with quality and improvement goals. HealthInsight Utah's first projects as a RHIC go back to the Utah Partnership for Value-driven Health Care and Chartered Value Exchange effort, which included engaging healthcare purchasers, health plans, providers, and consumers to participate in a multi-stakeholder collaborative.

HealthInsight Utah also served as one of 17 Beacon Communities in the nation. Funded by the Office of the National Coordinator for Health Information Technology, the Utah Beacon Community Cooperative Agreement Program (called Improving Care through Connectivity and Collaboration, or IC3) assisted roughly 70 primary care clinics throughout Salt Lake, Summit, and Tooele counties in Utah in using health information technology to generate dramatic and quantifiable improvements in healthcare quality, cost, and efficiency.

## Leadership

Juliana Preston, MPA, serves as HealthInsight Utah's executive director.

## Services/Expertise

Most of HealthInsight Utah's efforts are focused on educating healthcare professionals, patients and families, including:

- Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO): As a QIN-QIO, HealthInsight Utah works with providers and the community on multiple, data-driven quality initiatives to improve patient safety, reduce harm, engage patients and families, and improve clinical care locally and across the region. Part of this work involves learning and action network events, which include calls, webinars, and live meetings, and focus on best practice sharing, technical data requirements, standards of care, and other topics of interest to participants.
- Utah Department of Health Certification in Infection Control (CIC©): HealthInsight Utah provided a CIC© review course to the Utah Department of Health to help prepare infection prevention specialists for certification.
- Patient-Centered Outcomes Research Institute Program (PCORI) – As part of the PCORI grant, HealthInsight Utah held an event in the spring of 2016 that brought together patients, researchers, providers and payers to understand the value of patient-centered outcomes research. HealthInsight Utah is working towards creating a community network that will help connect researchers with the community to promote patient and community engagement in patient-centered outcomes research.
- Utah Action Coalition for Health – HealthInsight Utah is working to increase the number of formalized, evidence-based residency programs in Utah that support registered nurses in the transition into practice.

In all HealthInsight Utah initiatives, patients' and families' perspectives are the foremost priority. HealthInsight created a Patient and Family Advisory Council (PFAC) to serve as a platform to share stories and personal experiences, and to gain a deeper understanding of care.



End of Life Care Summit, April 2016

### **Networks/Partnerships**

As a neutral convener, HealthInsight Utah provides a safe place where people can come together and discuss healthcare issues and move quality improvement work forward.

HealthInsight collaborates with multi-stakeholder networks in Utah, including the Utah Health Information Network, Utah Department of Health, all major healthcare delivery organizations, many consumer organizations, and various provider associations. HealthInsight staff and leadership hold important positions on partner boards, collaboratives, and value initiatives in the community. Nationally, HealthInsight participates in the second round of the Total Cost of Care (TCOC) NRHI project and has greatly benefited from the learning of the initial five original communities in that project. Partnering with other RHICs has also informed HealthInsight Utah's approach to public reporting as part of the Qualified Entity program, and led to joint bidding on combined grant opportunities.

### **Major Accomplishments**

**End-of-Life Care:** HealthInsight Utah has been funded through the Utah Department of Health under the new State Innovation Model cooperative agreement from the Center for Medicare and Medicaid Innovation to focus on multiple aspects of advance care planning. HealthInsight Utah created an Advance Care Planning Advisory Group to focus on empowering patients and their families to engage in meaningful end-of-life conversations with their physicians, providing adequate training to providers in facilitating these critical discussions, and enhancing the portability and accessibility of documented preferences (Physician Order for Life Sustaining Treatment, or POLST, and other documents) at the time of need using a secure electronic process. This group has come together to plan Utah's first ever conference specifically targeting advance care planning challenges and successes, with hopes of improving awareness and education on end-of-life topics for providers, families, and the community.

HealthInsight Utah also launched Leaving-well.org, which is a comprehensive, consumer-friendly collection of information that covers virtually every aspect related to end-of-life – from legal and financial tips to health care.

**Care4Life – Diabetes Text Message Tool:** Through the Beacon Community project, HealthInsight Utah enacted the Care4Life interactive text-message program to address diabetes self-management. This program allowed patients to receive text reminders to take medications, attend doctors' appointments, and measure blood sugar levels. This inexpensive tool increased patient adherence and increased daily life satisfaction, with 91% of the more than 400 trial users stating that they would recommend the application.

**Registered Nurse Residency Programs:** The Utah Action Coalition for Health and HealthInsight Utah expanded Registered Nurse residency programs to eight hospitals across Northern Utah, with three additional hospitals planning to launch a program soon. As of spring 2016, approximately 375 RN residents have participated in the program.

**Utah HealthScape:** The development of UtahHealthScape.org made healthcare information about cost and quality available to patients and families in Utah. The site provides the most complete and accurate information available about the Utah healthcare landscape and includes a directory listing of over 5,500 doctors and 2,200 clinics across the state; quality ratings for hospitals, health plans, nursing homes, and home health



agencies, based on data collected from patient surveys and medical records by federal agencies and vetted by researchers and industry stakeholders; and simple, straightforward explanations of common health conditions and health-related concerns, such as access to care.

**Decline in Hospital Readmissions:** In the Medicare QIO work period that ended in July 2014, HealthInsight and QIOs across the country worked closely with providers and with federal, state, and private partners in local communities to improve care transitions and prevent hospitalizations and readmissions among Medicare beneficiaries. CMS findings showed that communities where QIOs played an active role in improving transitions achieved greater reductions in readmissions.

**Price Transparency:** In November 2014, HealthInsight Utah collaborated with the Utah Department of Health, Office of Health Care Statistics (OHCS) to release data about the cost of some of the medical services commonly provided when a baby is born, including differences in costs for a vaginal or caesarian birth in Utah. This information helps patients, particularly those who are uninsured, compare and possibly negotiate lower prices for these services.

**Total Cost of Care (TCOC):** HealthInsight has also partnered with OHCS to complete the All-Payer Claims Database (APCD) quality assurance process required for use of the Health Partners National Quality Forum certified Total Cost of Care and Resource Use indices. These metrics will be compiled as actionable reports highlighting areas for improvement at the provider group level.

**Qualified Entity (QE):** HealthInsight Utah has completed the recertification process with CMS to expand combined commercial and Medicare claims reporting to the Utah population. Quality measures for breast cancer screening and diabetes care have been approved by the Utah Department of Health Institutional Review Board and will be calculated using the Utah All Payer Claims Database and CMS Medicare fee-for-service claims. These measures will be assigned at the provider group level for public reporting later in 2016.

## The Future

HealthInsight Utah hopes to increase employer engagement in order to have their voice heard in the cost and quality of health care. HealthInsight is working with local healthcare providers in Utah to promote patient-centered care, make care safer and more affordable, augment transparency of cost and quality data, and improve population health. The organization will engage hospitals, nursing facilities, physician practices, home health agencies, Medicare beneficiaries and families, and related key stakeholders throughout the state to develop and apply proven strategies.

HealthInsight Utah's future patient-centered goals include developing electronic POLST registries for end-of-life care in four other states. HealthInsight intends to expand its work to engage the newly insured in the state and continue education on the *Choosing Wisely*<sup>®</sup> campaign with brokers, consumers, employers, and providers. HealthInsight Utah has also partnered with four community organizations on the Cambia Navigators project to design an innovative campaign educating newly-insured Spanish-speaking residents on how to navigate the healthcare system, utilize preventive services, and provide support to meaningfully interact with their healthcare providers. Finally, HealthInsight Utah plans to offer TCOC measures to providers, and produce quality metrics for ongoing public reporting in 2016 and beyond.

## Integrated Healthcare Association (IHA)



### History

Integrated Healthcare Association (IHA) was established as a California statewide association in 1994 to promote the continuing evolution of integrated health care – care that aligns the incentives of purchasers, payers, and providers, and achieves the best possible outcomes for patients and the general public. With a mission of creating breakthrough improvements in healthcare services through collaboration, IHA promotes quality improvement, accountability, and affordability for the benefit of all California consumers.

IHA brings together leaders from key sectors of health care to foster innovation through both individual and collaborative efforts. The organization is governed by a 44-member board of directors with equal representation from health plans, physician groups, hospitals and health systems, as well as additional representation from sectors including regulatory, pharmacy and biotechnology, consulting, technology, academia, purchasers, and consumer groups. IHA revenue sources include surcharges for program administration, membership dues, and private foundation grants.

### Leadership

Current executive leadership includes President and CEO Jeffrey Rideout, MD; Senior VP of Programs and Policy Jill Yegian, PhD; and VP of Performance Measurement Dolores Yanagihara, MPH, who led IHA and the California pay-for-performance (P4P) program through its transition to value-based P4P.

### Strategies

IHA creates credible, actionable information that enables sustainable improvement in California's healthcare system through multi-stakeholder collaboration. IHA is organized around projects that generate insights, improve accountability, and accelerate solutions.

**Insights** – IHA's projects generate insights and actionable information for industry leaders and policymakers to improve quality, reduce costs, and increase transparency in health care. Complex issues require a trusted, neutral convener that can solve problems and achieve results for all stakeholders—a role that IHA has held successfully for more than a decade.

**Accountability** – IHA works with stakeholders to advance performance measurement and incentives that are essential to high-value, integrated patient care, and enable public reporting of comparative performance information. IHA's regional and statewide initiatives include the California Value-Based P4P program—a statewide collaboration of 10 health plans and over 200 physician organizations which care for nine million patients.

**Acceleration** – IHA incubates pilot programs and demonstration projects, and collaborates with diverse stakeholders to accelerate integrated care. IHA's unique forum convenes healthcare leaders to assess industry-wide issues and activate data-driven solutions.

### Services/Expertise

IHA's specialties include performance measurement, data aggregation and analysis, public reporting, and multi-sector collaboration and engagement on a variety of programs and initiatives. IHA administers the California Value-Based P4P program, and has led

numerous demonstrations and grant-funded research projects. IHA provides thought leadership and experience to bring informed, meaningful improvements to the healthcare system.

### **Networks/Partnerships**

Under a grant from the American Board of Internal Medicine Foundation's *Choosing Wisely*<sup>®</sup> campaign, IHA is partnering with a variety of groups to reduce overuse of antibiotics for adult bronchitis, diagnostic testing for low back pain, pre-operative stress testing, imaging for uncomplicated headache, and repetitive complete blood count and chemistry testing. IHA's partners for this initiative include Sharp Rees-Stealy Medical Group in San Diego County; Sutter Health in the Sacramento, Central Valley, and San Francisco Bay areas; the California chapter of the American College of Physicians; the Center for Healthcare Decisions; and Blue Shield of California.

These project partners are also participating in a related effort, The Statewide Workgroup on Reducing Overuse, to address overuse of selected medical care across public and private payers. IHA's role is to provide technical assistance to the multi-stakeholder work group, which is led by the California Public Employees' Retirement System, the California Department of Health Care Services, and Covered California. Collectively, the three organizations purchase and manage healthcare services for approximately 15 million Californians.

IHA and the California Office of the Patient Advocate (OPA) partnered on the Medical Group Report Card, an initiative that resulted in the largest statewide multi-payer public report card to provide side-by-side comparisons of both quality and cost measures at the medical group level. Marking a milestone for healthcare transparency, consumers and purchasers can now compare side-by-side cost and quality ratings for more than 150 medical groups caring for about nine million commercially insured Californians. Additionally, IHA has provided data on Quality Performers for the OPA to publicly report for over a decade.

With these partnerships and IHA-led projects, California stakeholders have:

- Created a single performance-based measure set and public report card
- Used data aggregated from multiple payers to score results, significantly increasing reliability and trust
- Created a collaborative environment between California health plans and physician groups
- Implemented appropriate use, overuse, and cost efficiency measures implemented years ago to the current TCOC measures in the Value Based P4P program
- Harnessed the power of geographic hot-spotting from IHA's regional performance variation initiative to create targeted performance improvement initiatives

### **Major Accomplishments**

IHA has numerous accomplishments to date, including:

- Transitioning the California P4P program to a Value Based P4P program. The California P4P program, launched in 2003, is a story of consensus building and engagement. The program enables physician organizations to earn health plan incentive payments based upon performance against a set of quality and efficiency measures. Results are publicly reported and top performers are recognized in a yearly awards ceremony. Working with California health plans and physician organizations over the past 15 years, IHA's

Value Based Pay for Performance (VBP4P) program has grown into one of the largest alternative payment models in the country. Today, participants include 10 health plans and over 200 California physician organizations caring for over nine million Californians.

- Implementing and now reporting results on Total Cost of Care (TCOC), a key step in transitioning IHA's P4P program from focusing solely on quality to a value-based approach that measures both quality and cost. Since 2011, IHA's Value Based P4P program has calculated and risk adjusted the TCOC for individual physician organizations, based on actual payments for each health maintenance organization/ point of service enrollee's care, including professional, pharmacy, hospital and ancillary services, and consumer cost-sharing.
- Reporting physician organization-level Medicare Stars results, allowing for targeted quality improvement initiatives. IHA expanded its performance measurement reach by launching the Medicare Stars performance measurement reporting of physician organizations, including administratively-derived HEDIS (Healthcare Effectiveness Data and Information Set)-based Stars measures relevant to care delivery.
- Conducting regional variation work, including both HEDIS by Geography and Cost Atlas projects that will incorporate cost into the quality regional results. HEDIS by Geography is an online tool that allows users to view health plan HEDIS results by geographic area to gain a clearer picture of population health across California. Users can examine performance on six clinical quality measures and three resource-use measures by health plan product line, for about 19 million Californians, including commercial HMOs and preferred provider organizations, Medicare Advantage and managed Medi-Cal (California's Medicaid).
- Working to assess and improve encounter data issues associated with the delegated risk model. IHA has launched a multi-stakeholder initiative to assess and develop solutions to the existing challenges to complete timely and accurate encounter data. IHA is working with stakeholders to develop ways to standardize encounter data exchange processes.

### **Why Join NRHI**

Since joining NRHI in 2011, IHA has benefited from the network's national perspective and learnings gleaned from other RHICs. In particular, IHA's collaborative work with Minnesota Community Measurement on The DOCTOR project (an initiative to develop consumer-friendly reports on physician care) was strengthened through NRHI.

### **The Future**

IHA is partnering with the Pacific Business Group on Health (PBGH) and its California Quality Collaborative, as well as the Center for Care Innovations to support practice transformation. PBGH will receive up to \$18.4 million from CMS to develop a Practice Transformation Network (PTN), one of 29 nationally. This PTN will provide technical assistance to help 16 provider organizations with 4,800 clinicians to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. IHA will support the PTN by leading data collection and reporting by expanding its P4P web reporting portal, increasing the frequency of data collection and reporting, and expanding data to individual clinicians within the physician organizations.

## History

The North Coast Health Information Network (NCHIN) was formed in 2010 as a health information exchange (HIE) in order to provide electronic health record (EHR) interoperability between health data providers, labs, hospitals, and practices in Humboldt County, CA. Within three years, the non-profit's mission expanded to include community health improvement.

At the end of the Robert Wood Johnson Foundation's Aligning Forces for Quality grant, members of the NCHIN wanted to retain the skills, relationships, and interest in community care improvement developed during the initiative. Working closely with the Humboldt Independent Practice Association, NCHIN continues to facilitate the secure and appropriate sharing of electronic health and clinical data among diverse organizations in northern California, which they harness to conduct care improvement projects related to population health, patient experience, and cost.

## Leadership

Martin Love has served as the CEO of NCHIN since its founding. Rosemary Den Ouden is the current COO. In addition, two staffers from the California Center for Rural Policy (CCRP), Jessica Osborne-Stafsnes and Connie Stewart, have regular roles with NCHIN projects. Stewart leads many of NCHIN's non-clinical community activities, and Osborne-Stafsnes is a project manager.

The organization's diverse board includes community physicians, the public health branch director, chief executive and operating officers of the two local hospital systems, an IT manager, emergency department representatives from a federally qualified health center, the medical director of Partnership HealthPlan of California, a community member, and a representative from a clinic support organization.

## Strategies

To provide secure healthcare data sharing and catalyze improved health outcomes, NCHIN focuses on the following strategies:

- Organizing local healthcare leaders for community coordination and cooperation
- Organizing local community members to represent a "non-health provider" view of care, and placing patients in practices for care improvement activities. For example, NCHIN has established community leadership groups to study and make recommendations on local healthcare issues.
- Aggregating quality data from practice EHRs and the health information exchange
- Working toward the formation of an Accountable Community for Health across Humboldt County
- Participating in a current AcademyHealth HIE initiative to build electronic exchange between NCHIN and a county program for permanent and supportive housing



- Participating in community initiatives, including the SuperUtilizer Program, the Surgical Rate Project, Shared Decision Making program, the Clinical Referral Project, Chronic Pain and Prescription Drug Abuse Community Project, Practice Improvement Coaching, and Our Pathways to Health (a chronic disease patient self-management program from Stanford University)
- Participating in the Practice Transformation Network

### **Services/Expertise**

NCHIN's three main service areas are HIE technical assistance, data aggregation and measurement across practice EHRs for population health and reporting, and quality improvement coaching.

As a health information exchange, NCHIN supports FQHCs and others with clinical and healthcare event information for care coordination and patient engagement. Stemming from the Surgical Rate Project, which convened a group of clinicians to discuss the results of a rate report, as well as on the recommendation of the Community Group (a non-medical community leadership team), a no-cost Shared Decision Making program has been established to accept clinician and self-referrals.

NCHIN offers numerous programs that center around self-management of care and decision-making for chronic diseases. NCHIN also convenes meetings of The Community Group, which is comprised of non-healthcare leaders in the community, who gather monthly to learn about health, health care, social care, and cost in Humboldt.

In addition to its care coordination, health data expertise, and numerous self-management-related programs, NCHIN offers valuable quality improvement coaching to practices, and educational opportunities through the UC Davis School of Nursing for nurse practitioners and physician assistant students.

### **Networks/Partnerships**

NCHIN often works with the Pacific Business Group on Health, Integrated Healthcare Association, the California HealthCare Foundation, AcademyHealth, and RUPRI (Rural Learning Action Networks).

### **Major Accomplishments**

The Surgical Rate Project was a breakthrough project for NCHIN in numerous ways. The project's interventions – which included data presentation, review, and recommendations – were done in parallel across three groups: community members, PCPs, and surgeons. Community members recognized the wide variation in rates and found the issue compelling. They also observed the different expectations PCPs and surgeons have for decision-making, and their challenges in coordinating care. This effort resulted in the Shared Decision Making program, which emphasizes the importance of patients playing an active role in their care.

In the SuperUtilizer project, a local hospital and an FQHC revealed that common beliefs about why some patients had exceptionally high rates of emergency department use were inaccurate. The project demonstrated that a coordinated effort, which included care managers, could reduce those high rates for patients. The systems that were established at that time are still in place years later.

With so many national expectations of sustainable and transformative efforts, NCHIN's leadership team became skeptical about the efficacy and limited scope clinical projects, primary care practice transformation, and public reporting of HEDIS measures. Scanning the country for successful communities, the group organized a visit in 2014 to Grand Junction, CO, an area nationally recognized for cutting healthcare costs while maintaining high quality. Many Humboldt health and social care leaders took part, and the trip motivated them to form a group that is beginning to work cooperatively to improve care and lower cost in the county. Their efforts include trying to establish an Accountable Community for Health (ACH).

### **Why Join NRHI**

The Aligning Forces initiative brought community improvement resources along with a network of peers, leaders, and innovators. By joining NRHI in 2015, NCHIN is once again "plugged in" and aligned with an organization that shares its project goals.

### **The Future**

NCHIN will continue its work to lower the technical barriers for providers, systems, and patients to benefit from the wealth of health data available today, and to cultivate relationships with both medical and non-medical stakeholders to drive population health improvements.

## Oregon Health Care Quality Corporation (Q Corp)



### History

The Oregon Health Care Quality Corporation (Q Corp) plays a unique role as an independent, multi-stakeholder organization leading community-based initiatives focused on improving the quality, affordability, and patient experience of health care in Oregon. The organization was founded in 2000 by the state coalition of healthcare purchasers to spearhead quality improvement and reporting initiatives. Q Corp is dedicated to improving Oregon's health care by leading community collaborations, producing high-quality measurement and analysis, and embracing rapid changes and innovations within the healthcare field.

### Leadership

Under the leadership of a small number of staff members in its early years, Q Corp built relationships with a variety of stakeholders, including the health plans, that would eventually join Q Corp's voluntary claims data collaborative. Mylia Christensen, the current executive director, came on board in 2010 and has led the organization through extensive growth in both staff and budget. Q Corp has diversified its funding sources to include contributions from health plan data suppliers, grants, and state and federal contracts.

Q Corp's Board of Directors includes 21 senior representatives of state agencies, health plans, hospitals, employers, and consumer and medical groups. Subcommittees that guide program development and reporting initiatives include the expertise and perspective of over 150 health system stakeholder volunteers.

### Strategies

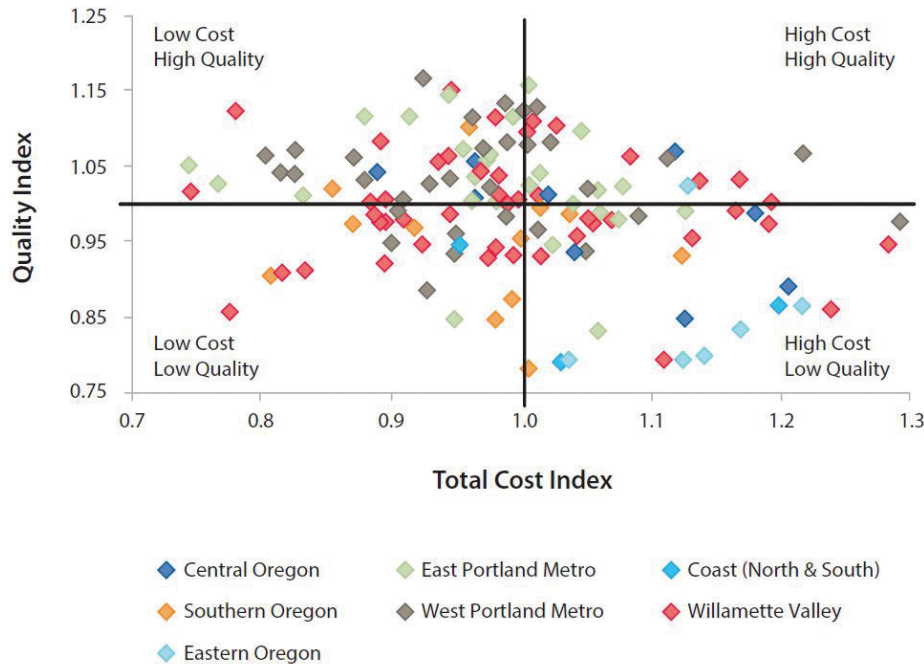
Q Corp advances the Triple Aim through a variety of transparency, affordability and transformation projects.

**Transparency:** Q Corp brings the healthcare community together to produce unbiased information about healthcare quality, utilization, and cost in Oregon. Reports for consumers, employers, providers, health plans, policymakers, and others are guided by a multi-stakeholder Measurement and Reporting Committee. In recent years, Q Corp has leveraged its claims database to provide custom analytics to a variety of healthcare organizations. The state of Oregon has also called upon Q Corp to validate metrics for coordinated care organizations, and enhance the health insurance rate review process to increase price transparency.

**Transformation:** Q Corp manages the Patient-Centered Primary Care Institute, an initiative to accelerate primary care transformation in Oregon by partnering with healthcare providers, clinic staff, technical experts, patients, quality improvement professionals, and others to share valuable knowledge and resources. The Institute connects practices to resources through an interactive website, in-person trainings, practice coaching, and a learning network for individuals supporting the quality improvement and medical home efforts of primary care practices.

**Affordability:** With a track record of producing reliable quality and utilization data, Q Corp took on the challenge of reporting on healthcare cost. In 2015, after years of preliminary work to engage the community in defining cost reporting priorities, Q Corp rolled out its first round of Total Cost of Care Clinic Comparison Reports. These reports include cost, utilization, and quality measures and were provided to more than 150 primary care

### Clinic Total Cost Index vs. Quality Index by Region



Measurement Period: January 1, 2013 - December 31, 2013

Oregon Health Care Quality Corporation (2015) *Information for a Healthy Oregon*, access the report at [www.q-corp.org](http://www.q-corp.org)

practices. A second round of reports will be released in 2016, and reports for additional audiences will follow. Q Corp has also leveraged its claims database to support several payment reform projects, bringing together community leaders to develop and implement payment methodologies and care models that improve the quality of care delivered, while also reducing costs.

### Services/Expertise

In partnership with Oregon’s largest health insurers, the Oregon Health Authority and CMS, Q Corp has developed a comprehensive claims database that includes 84% of the fully insured population, 33% of the self-insured population, 100% of the Medicaid population, and 90% of the Medicare population in Oregon, representing care for over three million patients since 2005. With this robust data, Q Corp produces reports and analytics that inform the work of those who provide and pay for health care.

Q Corp’s approach is predicated on the notion that achieving the Triple Aim can only be done with many perspectives and interests at one table. Whether the goal is reducing hospital readmissions, engaging consumers, measuring and reporting patient experience, providing technical assistance for primary care, or payment reform, Q Corp has demonstrated a unique ability to bring people together to produce tangible results.

Q Corp offers health system stakeholders information, training, and support to deliver the best care possible. Educational resources are available on its website, as well as through the Patient-Centered Primary Care Institute, including recorded webinars, resource libraries, online learning modules, recorded interviews and lectures, and a regularly updated blog. Through its Total Cost of Care program, Q Corp has brought physicians to a National Physician Leadership Summit to better understand and use cost measurement to improve care.

### **Networks/Partnerships**

Q Corp's dataset is the most validated and utilized claims database in Oregon. Reports on quality, utilization, and cost metrics to providers, health plans, and the public would not be available without it. This dataset also allows Q Corp to produce pioneering analytics and reporting to help providers and health systems improve cost of care. Q Corp's approach to reporting Total Cost of Care was informed by the work of RHIC colleagues in Maine.

The state of Oregon has engaged in significant system redesign efforts over the last several years. Q Corp has been a key partner, including serving on data advisory groups, and leveraging experience to lead projects as a subcontractor. Through Q Corp convening projects, important work is not only started, but sustained. For example, Q Corp trained health systems on engaging patients and families as leaders, and connected primary care providers to medical home resources. In addition, Q Corp is a sub-contractor to HealthInsight in their role as the Quality Improvement Organization (QIO) in Oregon.

### **Major Accomplishments**

One of Q Corp's earliest projects, a Chronic Disease Data Clearinghouse that merged claims data from 11 health plans to provide clinicians with better tools to manage diabetes and asthma care, typifies the kind of work the organization still does today. In 2007, Q Corp became one of 16 organizations nationwide selected to participate in Aligning Forces for Quality (AF4Q), a program of the Robert Wood Johnson Foundation. Participating in AF4Q provided momentum to Q Corp's voluntary data collaborative, which over the years has allowed the organization to aggregate claims data and report it publicly to consumers, privately to primary care practices, and to the health plans that supply the data. The data collaborative also empowers Q Corp to produce an annual statewide report for healthcare leaders.

In addition to creating a robust voluntary claims data collaborative, Q Corp has served as the leader of collaborative projects around technical assistance and data, and is a key partner in Oregon's health transformation efforts.



Q Corp's partners and fans celebrate the 15th Anniversary

### **Why Join NRHI**

Q Corp joined NRHI in 2008. Support from fellow RHICs and NRHI has been critical to the organization's development of the Total Cost of Care program. Participating in NRHI allows Q Corp to serve as a link between national and local improvement efforts. The connection among RHICs that NRHI offers provides significant value to individual communities, allowing regional groups to explore sustainability models while also combining efforts to leave a national footprint.

### **The Future**

Q Corp aspires to leverage its varied experience in support of a holistic approach to system transformation that weaves together actionable data, payment reform, and patient-centered, high-value care.



# Washington Health Alliance (The Alliance)



## History

In the early 2000's, then-King County, WA Executive Ron Sims was driven to stem the rising cost of health coverage for public employees. That drive led to the creation in 2003 of the King County Health Advisory Task Force, which brought together Dr. Ed Wagner from the MacColl Institute, Dr. Alvin Thompson from the University of Washington, and benefits representatives from purchasers, providers, and academic experts to reduce the misuse of care and improve quality, rather than cut benefits or shift costs to King County employees and their families. In 2004, the task force recommended the creation of the Washington Health Alliance (the Alliance; formerly known as the Puget Sound Health Alliance).

The Alliance builds strong partnerships among purchasers, doctors, hospitals, health plans, patients and others to promote health and improve quality and affordability by reducing overuse, underuse, and misuse of healthcare services.

The Alliance's membership has grown to more than 185 organizations across Washington. Among the private and public employers and union trusts that are Alliance members are Boeing, Starbucks, the Washington State Health Care Authority, King County, and the Washington Teamsters Health Trust. In addition, members include all of the health plans in the market, the vast majority of major hospitals and physician groups, government agencies, community-based organizations, educational institutions, pharmaceutical companies, and consumers.

## Leadership

Margaret Stanley served as the Alliance's first executive director. She was succeeded in 2008 by Mary McWilliams, who held the position until current Executive Director Nancy Giunto joined the organization in 2014. Other key Alliance leaders include Deputy Director Susie Dade, Director of Data Management and Analytics Mark Pregler, and Director of Communication and Development John Gallagher. The Alliance's committee structure is designed to involve many senior healthcare leaders from across the state. It features a multi-stakeholder board, with a majority of purchasers.

## Strategies

The Alliance's overall vision is for providers and hospitals in the region to rank in the top ten percent nationally in delivering quality, evidence-based care that reduces unwarranted variation, resulting in a significant reduction in medical care costs.

## Services/Expertise

The Alliance's core work is data analysis and public reporting. In addition to information that the organization makes publicly available, the Alliance provides custom reports to members who are data suppliers. These reports compare the performance of the data supplier's population to the statewide average.

The Alliance also serves as an important community convener. For example, organizational leadership brought together stakeholders to develop the Washington State Common Measure Set on Health Care Quality and Cost. Under a grant from the state, the Alliance guided three technical work groups that recommended the components of the Common

Measure Set. These recommendations were finalized by the Performance Measures Coordinating Committee (PMCC), a diverse group of representatives appointed by the Governor's office from health research, medicine, behavioral health, insurance plans, public health, healthcare practices and specialties, consumer groups, minority populations, the business community, and other areas. The Alliance continues to facilitate this effort, with additional measures to the Common Measure Set recently approved.

The Alliance participates in educational efforts for healthcare workers and consumers. It co-sponsors the Clinical Performance Improvement Network, a series of webinars aimed at educating health professionals about ways to bolster quality in their practices. The series is offered in conjunction with the Washington State Medical Association and includes continuing medical education credits for attendees. Additionally, the Alliance has a robust consumer education campaign to help patients manage their health and health care. The campaign, called Own Your Health, focuses on helping consumers understand concepts (such as the importance of having a primary care provider and value-added healthcare services) to empower them to play a more active role in choosing the right care for them.

### **Networks/Partnerships**

The Alliance is an active member in the NRHI network. In addition to NRHI, the Alliance is also a member of the National Business Coalition on Health and the National Quality Forum. The Alliance is working with the Accountable Communities of Health, nine mini-RHICs established around Washington with financial support from the State Innovation Model (SIM) grant. Their focus is on improving population health and supporting the integration of behavioral health and primary care at the local level.

As a purchaser-led organization, the Alliance works closely with businesses and labor union trusts to improve the value of care in the state. The Alliance also reaches out to non-members to educate them about changes underway in Washington relating to the SIM grant. Several purchaser members are also governments, such as the state Health Care Authority and King County, and serve on the Alliance's board. Staff members serve on a variety of outside committees, including the Robert Bree Collaborative and the University of Washington Health Promotion Research Center's Community Advisory Board.

### **Major Accomplishments**

The Alliance had several significant accomplishments during its initial years of operation. Beginning in 2005, it sponsored Clinical Improvement Teams to focus on multiple health conditions: asthma, diabetes, heart disease, low back pain, depression prevention, and pharmaceuticals. In 2006, the Alliance adopted the National Quality Forum framework for using evidence-based care guidelines to drive performance measurement and reporting. The Alliance called for hospitals and physician clinics to bar pharmaceutical sales representatives from visiting doctors and distributing free samples and other marketing items. The Alliance also became one of the first four communities named by the Robert Wood Johnson Foundation as part of its national signature program, Aligning Forces for Quality.

In 2007, U.S. Department of Health and Human Services Secretary Michael Leavitt designated the Alliance as the nation's first Community Leader for Value-Driven Health Care. That same year, the Alliance announced agreements with 16 area health plans and self-funded purchasers to supply data to create the region's first public report on the quality of health care provided in local clinics.

After laying the initial groundwork for data-driven, community-oriented health improvement, the Alliance has centered its efforts on three main areas:

**Transparency:** The Alliance has evolved into the state's go-to organization for information about healthcare quality and patient experience and has contributed to greater healthcare transparency across Washington. It produces a Community Checkup report, which examines quality at the medical, clinic, and hospital level. In 2015, the Alliance expanded the report to encompass the statewide Common Measure Set, which includes reporting at the health plan, Accountable Community of Health, and county level. The Alliance has also published numerous reports on patient experience, health plan performance, *Choosing Wisely*<sup>®</sup> components, population procedures rates, variation in healthcare pricing, and resource use for high-volume hospitalizations. These reports are foundational to improving value in health care because they highlight areas for improvement.

**Collaboration and Convening:** The Alliance has established a strong working relationship with all of Washington's healthcare stakeholders, including purchasers, plans, providers, and consumers. Prior to the Alliance's existence, there was no single safe table for all of these entities to join together, nor an organization that could facilitate sometimes difficult conversations about how to improve the healthcare system. Today, senior leaders in the business and medical communities, as well as leaders within health plans and government, are active participants on the Alliance board and committees. The Alliance's reputation has allowed it to convene senior physician leaders to advance the work of *Choosing Wisely*<sup>®</sup> in Washington. The state has capitalized on the Alliance's experience as a convener to drive the development and maintenance of the state's Common Measure Set.

**Community Support:** The Alliance is widely recognized as an important community asset within the state, evidenced in part through serving as the state's voluntary all-payer claims database (APCD) since 2007. The Alliance was instrumental in advising legislators through the process of crafting a law for a state-mandated APCD. In addition, the state has contracted with the Alliance to support development of the Washington State Health Innovation Plan and significant portions of its SIM work.

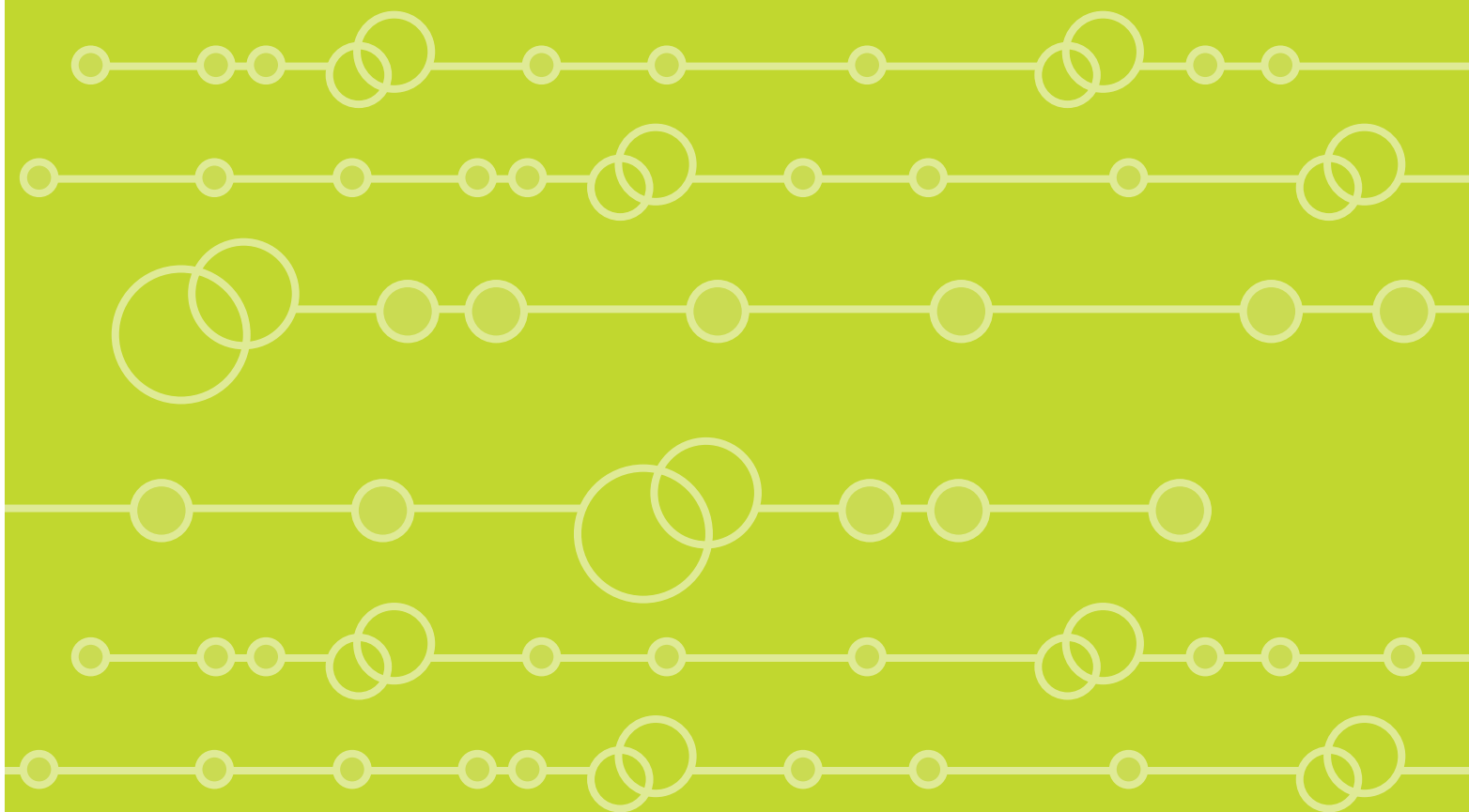
### **Why Join NRHI**

The Alliance values its membership in NRHI's network of trusted colleagues from around the nation who are doing similar work. The Alliance relies on NRHI leaders for learning background on key issues, as well as for advice on approaches to initiatives and strategies for overcoming challenges. Since time and resources are precious, there is no reason to start from scratch when there is an opportunity to leverage the work of others. The Alliance is pleased to offer advice and assistance to those on a similar journey.

### **The Future**

The Alliance is focused on strengthening its reputation as a state and national thought leader in improving healthcare value, including through increased transparency of quality and price data. Toward that end, the Alliance is enhancing its ability to aggregate, analyze, and provide information that leads to greater healthcare transparency. Additionally, the Alliance aims to diversify its revenue streams (currently derived from membership contributions and grant funding) and grow membership.

# Conclusion



## **Ensuring Successful Reform of America's Healthcare System**

The federal Patient Protection and Affordable Care Act (PPACA) of 2010 addressed one of the major barriers healthcare providers have faced in delivering high-quality, coordinated care: the lack of healthcare coverage for millions of Americans. It also created new mechanisms by which the Medicare and Medicaid programs could pay providers in ways that support higher value instead of higher volume of care. However, because health care is actually delivered by physicians, hospitals, and other healthcare providers, not by the federal government, and because most patients will continue to have their healthcare services paid for by private health insurance, the nation's ability to achieve higher-quality, more affordable health care will depend on the ability of individual communities to bring all of the stakeholders together to forge feasible solutions. This means that Regional Health Improvement Collaboratives will be essential partners to enable federal initiatives to be successful.

Although state governments will be playing an increasingly central role in healthcare reform in the future, partly as a result of the programs in the PPACA, they will not supplant the roles of Regional Health Improvement Collaboratives. While the regulatory powers and financial resources of state governments give them some unique strengths, such as the ability to mandate the submission of quality and cost data by providers and payers and the ability to provide anti-trust safe harbors to help establish multi-payer payment reforms and help independent providers coordinate their services, it is difficult for state governments to support multi-year healthcare transformation efforts through changes in state administrations and changes in fiscal priorities, and it is difficult for them to balance regulatory enforcement powers with programs to facilitate provider improvement. In contrast, the independence, nonpartisanship and stakeholder governance of Regional Health Improvement Collaboratives provides greater ability to support providers through multi-year transformation efforts and to do so in a way that can be adapted to the unique needs of individual geographic regions. Consequently, the greatest success in healthcare transformation will likely come from strong partnerships between state governments and Regional Health Improvement Collaboratives.

## **Sustainability of Regional Health Improvement Collaboratives**

All of the work done by Regional Health Improvement Collaboratives is challenging, but one of the most challenging tasks Collaboratives face is obtaining adequate funding to support their work. Collaboratives typically obtain their funding from three types of sources:

- **Membership "Dues."** Some Regional Health Improvement Collaboratives rely on annual financial contributions from the healthcare stakeholders in the community. Unlike dues payments made to many professional associations, however, these payments will usually be treated as tax-deductible contributions because of the charitable tax status of the Collaborative. These types of payments are critical because they provide flexible funding to cover the operating costs of the Collaborative (rather than being restricted to particular programs).



- **Grants.** Many Regional Health Improvement Collaboratives rely on grants from foundations and government agencies to support their programs. In some cases, Collaboratives receive unrestricted operating grants from foundations which can be used to fund general operations, particularly in the early years of their existence, but more typically, foundation grants will be restricted to use for specific projects and time-limited activities.
- **Fees for Services.** Some Regional Health Improvement Collaboratives provide specific services to healthcare providers or others for which they charge a fee. For example, some Collaboratives provide consulting services or coaching to healthcare providers to help them improve their quality of care, or offer courses in quality improvement for the employees of healthcare providers.

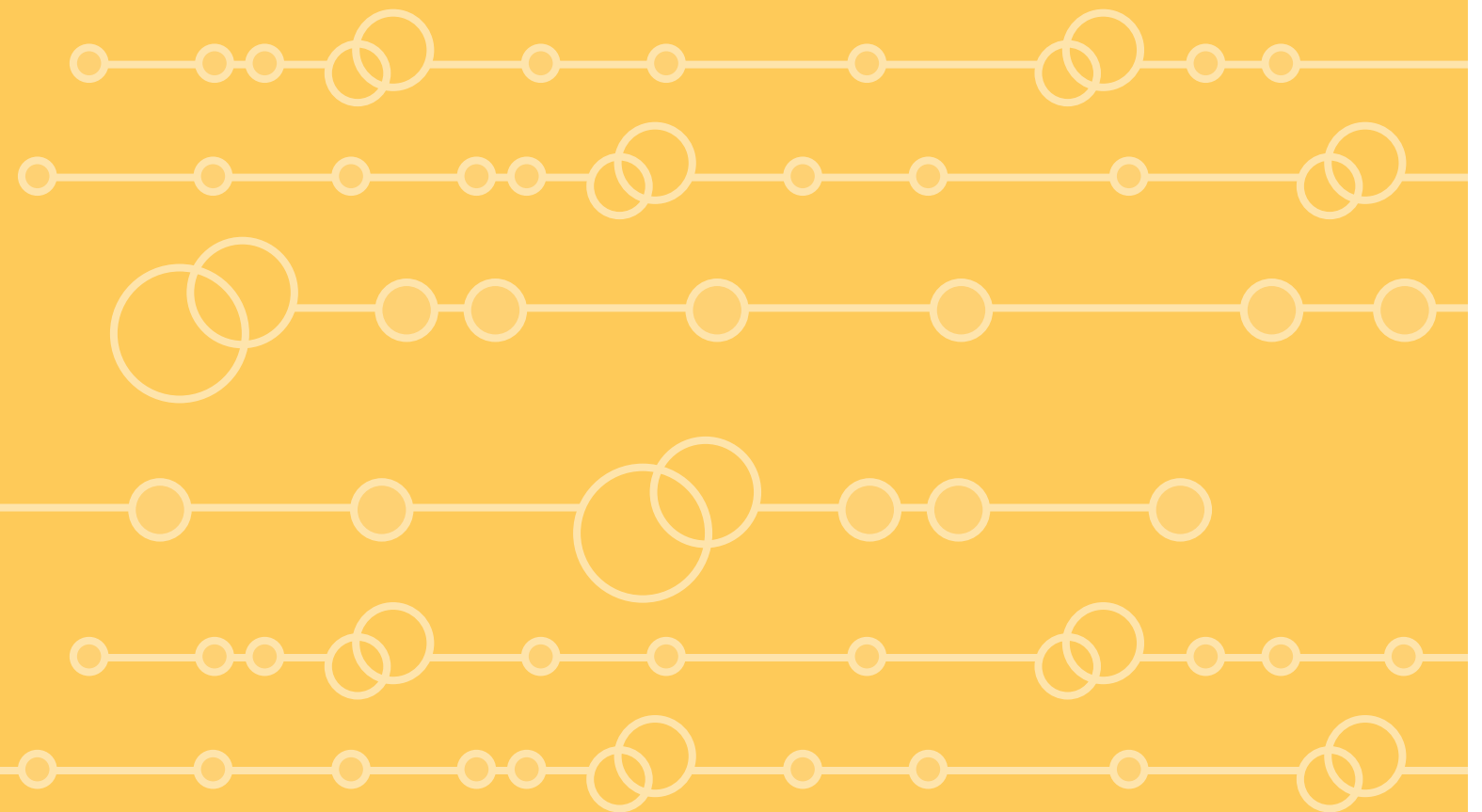
Despite the key role that Regional Health Improvement Collaboratives can play in ensuring the success of federal healthcare reforms in local communities, there is currently no federal funding program that provides support for the administrative operations of Regional Health Improvement Collaboratives. The Beacon Community Cooperative and the Regional Extension Programs were established through the Office of the National Coordinator for Health Information Technology at HHS, and did provide significant funding to a number of communities for multi-stakeholder healthcare improvement activities. But since the funding came through the 2009 American Recovery and Reinvestment Act, they were explicitly time-limited programs and have expired.

Likewise, during the past three years, a number of RHICs received funding from the Center for Medicare and Medicaid Innovation to mount large scale demonstration projects, but most of these have concluded. In addition, in 2014 the Robert Wood Johnson Aligning Forces for Quality program, which generously supported a number of RHICs, ended and no comparable program has taken its place. Some limited funding is available to a few RHICs through the CMS-funded Practice Transformation Network, the State Improvement Model programs, and the Hospital Engagement Network.

In the years ahead, it will be critical for Regional Health Improvement Collaboratives to have adequate resources both to maintain their current programs and to address the exponentially increasing demands that will be placed on them by the rapid implementation of new healthcare payment and delivery reforms. Although program-specific funding is desirable, unrestricted funding is essential to support the core operations of a Collaborative and to provide the flexibility to pursue new opportunities in innovative ways. In addition, if Collaboratives are to remain truly multi-stakeholder, community-based organizations, those resources will need to come from all stakeholders in their communities, as well as from state and federal government sources.

The greatest success in healthcare reform will be achieved if every community in the nation focuses on addressing the most important quality issues in that community, with support from both consumers and a broad range of healthcare providers, with participation by all payers, and with effective local mechanisms for monitoring implementation and resolving problems. Regional Health Improvement Collaboratives are an essential mechanism for accomplishing this, and consequently, supporting them should be a national priority.

# Appendices



## Current NRHI Projects

1. **Getting To Affordability (Total Cost of Care Phase II):** With support from the Robert Wood Johnson Foundation, NRHI is leading a multi-regional innovation initiative focused on producing, sharing, and using information about the total cost of care.
2. **Collaborative Health Network (CHN):** Through CHN, NRHI provides trusted peer-to-peer forums and programs to support ‘HealthDoers’ working to improve community health and health care.
3. **Support and Alignment Network (SAN):** NRHI is one of ten SANs in the Center for Medicare and Medicaid Innovation’s (CMMI) initiative providing learning programs and support to networks of clinicians throughout the country engaging in delivery system and payment reform.
4. **Healthcare Delivery Systems Analysis:** With funding from the Agency for Healthcare Research and Quality and the National Bureau of Economic Research, NRHI is leading a multi-regional initiative to understand how and why variation in quality, cost, and patient experience occurs between and within four states. NRHI’s efforts focus specifically on the impact of delivery systems.
5. **National Payment Reform Summit:** With support from the Robert Wood Johnson Foundation, NRHI convenes national and local leaders in payment reform to tackle and address the barriers standing between our existing dysfunctional healthcare system and achieving better health and care for our country at lower costs.
6. **Choosing Wisely®:** With support from the American Board of Internal Medicine Foundation, NRHI is helping regional collaboratives throughout the country engage their communities in conversations aimed at reducing unnecessary medical tests and healthcare procedures.
7. **HealthDoers Series:** As part of a grant from the California Health Care Foundation, NRHI hosts monthly discussions for the HealthDoers network on critical topics such as: integrating behavioral health into primary care; engaging communities around advance directives and end-of-life care; and sustaining financing for quality improvement initiatives.
8. **SCALE:** With support from the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation, NRHI is establishing systems for learning and evaluation to spread efforts toward a Culture of Health, with a goal of improving the health of 100 million people.

# Regional Health Improvement Collaboratives Featured In This Edition Of **ROOTS**

## **Network for Regional Healthcare Improvement**

217 Commercial Street, Suite 500  
Portland, ME 04101  
207-747-5104  
nrhi.org

## **Aligning Forces for Quality – South Central PA**

116 South George Street, 3rd Floor  
York, PA 17401  
717-801-4823  
aligning4healthpa.org

## **Community First, Inc.** (associate member)

280 Ponahawai Street, Suite 203  
Hilo, HI 96720  
808-675-2750  
communityfirsthawaii.org

## **Finger Lakes Health Systems Agency**

1150 University Avenue  
Rochester, NY 14607  
585-224-3101  
flhsa.org

## **Greater Detroit Area Health Council, Inc.**

407 E. Fort Street, Suite 600  
Detroit, MI 48226  
313-963-4990  
gdahc.org

## **Health Care Improvement Foundation** (associate member)

Ten Penn Center  
1801 Market Street, Suite 710  
Philadelphia, PA 19103  
215-563-2444  
hcfonline.org

## **Healthcare Collaborative of Greater Columbus**

1429 King Avenue, Suite 200  
Columbus, OH 43212  
614-906-2440  
hcgc.org

## **HealthInsight Nevada**

6830 West Oquendo Road, Suite 102  
Las Vegas, NV 89118  
702-385-9933  
healthinsight.org

## **HealthInsight New Mexico**

5801 Osuna Road NE, Suite 200  
Albuquerque, NM 87109  
505-998-9898  
healthinsight.org

## **HealthInsight Utah**

756 East Winchester Street, Suite 200  
Salt Lake City, UT 84107  
801-892-0155  
healthinsight.org

## **Institute for Clinical Systems Improvement**

8009 34th Avenue South, Suite 1200  
Bloomington, MN 55425  
952-814-7060  
icsi.org

## **Integrated Healthcare Association**

500 12th Street, Suite 310  
Oakland, CA 94607  
510-208-1740  
iha.org

## **Kentuckiana Health Collaborative**

1930 Bishop Lane, Suite 1023  
Louisville, KY 40218  
502-238-3603  
khcollaborative.org

**Louisiana Health Care Quality Forum**

8550 United Plaza, Suite 500  
Baton Rouge, LA 70809  
225-334-9299  
lhcf.org

**Maine Health Management Coalition**

11 Bowdoin Mill Island, Suite 260  
Topsham, ME 04086  
207-844-8106  
mehmc.org

**Massachusetts Health Quality Partners**

42 Pleasant Street, Suite 3  
Watertown, MA 02472  
617-600-4621  
mhqp.org

**Midwest Health Initiative**

8888 Ladue Road, Suite 250  
St. Louis, MO 63124  
314-721-8715  
midwesthealthinitiative.org

**Minnesota Community Measurement**

3433 Broadway Street, N.E.  
Broadway Place East, Suite 455  
Minneapolis, MN 55413  
612-455-2911  
mncm.org

**New Jersey Health Care Quality Institute**

Stone House at Carnegie Center  
3628 Route 1  
Princeton, NJ 08540  
609-452-5980  
njhcqi.org

**North Coast Health Improvement  
and Information Network**

2662 Harris Street  
Eureka, CA 95503  
707-267-9581  
northcoasthin.org

**Oregon Health Care Quality Corporation**

520 SW 6th Avenue, Suite 830  
Portland, OR 97204  
503-241-3571  
q-corp.org

**Pittsburgh Regional Health Initiative**

650 Smithfield Street, Suite 2400  
Pittsburgh, PA 15222  
412-586-6700  
prhi.org

**The Health Collaborative**

2100 Sherman Avenue, Suite 100  
Cincinnati, OH 45212  
513-618-3600  
healthcollab.org

**Washington Health Alliance**

600 Stewart Street, Suite 824  
Seattle, WA 98101  
206-448-2570  
wahealthalliance.org

**Wisconsin Collaborative for  
Healthcare Quality, Inc.**

7974 UW Health Court  
P.O. Box 628578  
Middleton, WI 53562  
608-826-6838  
wchq.org







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