

NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT

Regional Coalitions for Healthcare Improvement: Definition, Lessons, and Prospects

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Introduction

America, despite spending 16 percent of the GDP on healthcare—a far higher portion than another other country—has fallen short on quality.^{a,b} Reports about quality problems by the Institute of Medicine and others^{c,d,e,f,g} have engendered a national debate about how to improve healthcare quality. This conversation is producing points of consensus on the value of evidence-based healthcare, measurement and reporting of performance, and reward for results. This report examines the effectiveness of regional coalitions in leading and implementing such initiatives, based on their understanding of local marketplace issues and ability to mobilize local energy for change.^h

NRHI Member Coalitions

Institute for Clinical Systems Improvement (ICSI), Minnesota

Massachusetts Health Quality Partners (MHQP)

Minnesota Community Measurement (MNCM)

California Cooperative Healthcare Reporting Initiative (CCHRI) and Breakthroughs in Chronic Care Program (BCCP), both operated by the Pacific Business Group on Health (PBGH), California

Pittsburgh Regional Healthcare Initiative (PRHI)

Wisconsin Collaborative for Healthcare Quality (WCHQ)

It was prepared by the Network for Regional Healthcare Improvement (NRHI), an association of quality coalitions across the country. NRHI's purpose is to define regional coalitions, describe their achievements and challenges, identify measurements for success, and offer ideas about their role in the national effort to improve healthcare quality.

The Network for Regional Healthcare Improvement (NRHI) originated in 2004 when the leaders of two regional healthcare coalitions, one in Minnesota and one in Pittsburgh, began to talk by telephone to explore topics of common interest. Within a few months, they invited three more coalitions to join in, and one more joined later. Today there are six member coalitions (see box) participating in the monthly teleconferences. With support from the Robert Wood Johnson Foundation (RWJF), NRHI held its first meeting at ICSI in Bloomington, Minnesota, in September 2005. Representatives from RWJF, Centers for Medicare and Medicaid Services (CMS), and Institute of Medicine (IOM) also attended. This report combines the proceedings of the meeting with a report about the role of regional quality coalitions.

Executive Summary

America, despite spending 16 percent of the GDP on healthcare—a far higher portion than another other country—has fallen short on quality.^{1,2} Reports about quality problems by the Institute of Medicine and others^{3,4,5,6,7} have engendered a national debate about how to improve healthcare quality. This conversation has produced points of consensus on the value of evidence-based healthcare, systematic improvement of care processes, measurement and reporting of performance, and reward for results.

This report examines the role of regional coalitions in leading and implementing such initiatives, based on their understanding of local marketplace issues and ability to mobilize local energy for change.⁸ It was prepared by the Network for Regional Healthcare Improvement (NRHI), a newly formed association of quality coalitions across the country, including:

- Institute for Clinical Systems Improvement (ICSI), Minnesota
- Massachusetts Health Quality Partners (MHQP)
- Minnesota Community Measurement (MNCM)
- California Cooperative Healthcare Reporting Initiative (CCHRI) and Breakthroughs in Chronic Care Program (BCCP), both operated by the Pacific Business Group on Health (PBGH), California
- Pittsburgh Regional Healthcare Initiative (PRHI)
- Wisconsin Collaborative for Healthcare Quality (WCHQ)

NRHI defines a regional coalition as:

- A nonprofit legal entity, aimed at serving the public good in its region through the improvement of health and healthcare.
- A standing organization rather than a series of projects.
- Made up of voluntary members that are organizations, not persons.
- Limited to a defined geographical area.

- Organized around a defined program of action for improving healthcare in its region. Programs consist of one or more of the following five activities:
 1. public reporting of healthcare performance;
 2. achieving agreement on how to prevent and manage diseases;
 3. assisting healthcare delivery organizations to improve their processes and systems of care;
 4. coordinating a program of reward for results, including pay for performance; and
 5. enabling member organizations to exchange electronic healthcare information.

Most NRHI organizations are engaged in public reporting. Although none of the current public reporting is at an individual physician level, there are discussions about the political, methodological, and financial issues involved. Among the various stakeholders in regional collaboration, there is an ongoing tension between what consumers want and need, what purchasers want them to have, and what the physician community is willing to accept in the public arena.

There is no question that the public reporting of data among NRHI organizations is fueling interest in quality improvement among those being measured. One of the most critical goals of NRHI is to support improvement to healthcare delivery organizations. There are two key challenges: (1) cultivating and teaching medical leadership to do systems improvement and other quality improvement work; and (2) engaging a deeper level of commitment from practicing physicians and healthcare delivery organizations to improve processes and outcomes.

Numerous initiatives are underway to establish quality measurement and improvement programs at the national level. Efforts by the Institute of

Medicine, The Ambulatory Care Quality Alliance (AQA), CMS, and the Robert Wood Johnson Foundation are among them. Although consensus is growing that healthcare improvement goals and measures should be established and overseen nationally, regional coalitions can and should play an essential role in the success of such national efforts. Regional coalitions bring critical local conditions and sensitivities into key areas of quality measurement and reporting. Such regional organizations are in the best position to create data collection and aggregation platforms, organize incentive arrangements, and provide support for improvement action among providers in their areas.

It is unrealistic to expect that the whole country will become organized into regional coalitions in the foreseeable future; some regions do not have the requisite marketplace conditions, and some have alternative structures in place. Nonetheless, the prospect of having a voice in the creation of national programs provides an incentive for the establishment of regional coalitions. NHRI was formed to bring together regional organizations engaged in similar work and experiencing similar challenges. With sufficient funds to formalize the organization, NHRI can serve as an effective mechanism for establishing a collective voice for regional coalitions in the national arena; assuring communication among regional coalitions on national initiatives and other topics of common interest; sharing best practices among regional coalitions for healthcare improvement; and providing assistance to emerging regional coalitions.

The promise of regional coalitions for healthcare improvement is that they can provide a local focus for energies for improvement and respond quickly and accurately to local circumstances. Through their deep understanding of local facts on the ground, they can move national and regional efforts to improve healthcare.

What Is a Regional Coalition?

A regional coalition for healthcare improvement is defined by NRHI as an association of organizations that collaborate in a defined program to improve the quality of healthcare in a specific geographical area. Further, a regional coalition is:

- A **nonprofit legal entity**, aimed at serving the public good in its region through the improvement of health and healthcare.
- A **standing organization** rather than a series of projects.
- Made up of **voluntary members** that are organizations, not persons. Members may be healthcare delivery organizations, health plans, governmental units, employers, or citizen organizations.
- Limited to a **defined geographical area**. The area may be as large as one or more states, or as small as a metropolitan area. The local nature of coalitions maximizes the ability of its member organizations to identify with one another, to bond together around issues, and to challenge each other as peers.
- Organized around a **defined program** of action for improving healthcare in its region, rather than focusing on a particular disease or serving simply as a forum for discussion. Programs consists of one or more of the following five activities:
 1. public reporting of healthcare performance;
 2. achieving agreement on how to prevent and manage diseases;
 3. assisting healthcare delivery organizations to improve their processes and systems of care;

“A regional coalition for healthcare improvement is defined by NRHI as an association of organizations that collaborate in a defined program to improve the quality of healthcare in a specific geographical area.”

4. coordinating a program of reward for results, including pay for performance;
5. enabling member organizations to exchange electronic healthcare information.

It should be noted that the NRHI definition differs from that of Farley and colleagues in their report on regional coalitions.ⁱ They included broad community healthcare forums as coalitions. The definition also differs from that of Oswald, who included disease-specific projects.^j

Benefits of Regional Coalitions

Regional coalitions can provide a number of benefits to the healthcare organizations and the people in their region. They include:

- A neutral venue for wary parties to work together;
- A framework for coordinating program activities among members and with any partner coalitions in the same marketplace;
- Social validation of quality improvement achievements due to the visibility of the work being done;
- Motivation for continuously improving performance;
- Community expectation that certain levels of performance are unacceptable and that all performance should improve;
- Occasional economies of scale, for example, reporting public performance across multiple health plans;
- Improvement in the healthcare and cost of care in the region.

Requirements for Successful Start-up

“Potential member organizations must appreciate the value of acting together. . . . Organizations must be willing to set aside their interests in competing on the basis of quality.”

A number of marketplace conditions need to be in place for a regional coalition to be created.

- **Potential member organizations must appreciate the value of acting together.** Most organizations in a given market are independently attempting to address similar quality improvement agendas. With experience they often recognize the potential for powerful leverage in the marketplace when they act in concert.
- **Organizations must be willing to set aside their interests in competing on the basis of quality.** A key differentiator of markets that are more mature and ready for collaboration is an ability to work collectively on quality improvement.
- **Adequate start-up funds must be available.** Organizations that are willing to contribute financially to a coalition are likely to be invested in seeing it succeed.
- **Drivers for change must be apparent.** There must be substantial benefits for each participating organization, for example, pay for performance or improvement of the organization’s reputation. For a regional coalition to grow, it must fill a need in the local marketplace.
- **A credible convener is needed.** Trust can usually be achieved at the outset only by a respected convener who brings wary organizations together and defines an attractive zone of collaboration. The convener can be an organization or a person. Implementing business associate agreements and multi-party contracts are often necessary for organizations to be able to share clinical data and engage in process improvement discussions. In some cases, the convener continues with the coalition, and in other cases the role is temporary.
- **Effective political and operational leadership is necessary.** After the convener has brought the parties together, the coalition needs effective leadership to execute its program. Political and operational leadership require different skills, and are usually provided by two people, although the roles can be combined.

- **Certain marketplace characteristics are valuable.** Although not essential, a history of successful community-wide healthcare collaboration, and the existence of well established, multi-specialty group practices are helpful.

A formal tool for assessing readiness could be developed for leaders contemplating a regional coalition for a given marketplace. This type of assessment could direct attention to areas needing further development prior to launch in order to maximize the likelihood of success.

Program Design

NRHI coalitions are each structured differently in terms of participation and key program elements. As illustrated in Table A, none is engaged in all five program elements. Each market has different, collaborating organizations responsible for reporting performance and for technical assistance. There are gaps in some marketplaces, and program elements are provided piecemeal by different organizations in other regions.

“The NRHI members see the need for multiple, coordinated collaborations in a given marketplace to achieve all five of the program elements, whether by expanding their own program scope or by partnering with other organizations.”

In California, for example, one organization works on public reporting; another on technical assistance for quality improvement; and a third on pay for performance coordination. In Minnesota, ICSI leads the quality improvement assistance function, while its partner organization, MN Community Measurement, carries out the data collection and public reporting. In Massachusetts, MHQP focuses on data collection and reporting but has no partner organization to provide assistance for quality improvement.

The NRHI members see the need for multiple, coordinated collaborations in a given marketplace to achieve all five of the program elements, whether by expanding their own program scope or by partnering with other organizations. Another important function for NRHI coalitions is to facilitate market conditions conducive to integrating these key elements.

Running a Regional Coalition

Public Reporting

Most NRHI organizations are engaged in public reporting either directly or, in the case of ICSI, through a close working relationship with MN Community Measurement. The sole exception is the Pittsburgh Regional Health Initiative, which makes use of the separately reported data issued by the Pennsylvania Health Care Cost Containment Council. None of the public reporting is at an individual physician level. Political, methodological, and financial issues have dominated discussion about what level of public reporting is appropriate, who is the intended audience, and what is the purpose served by reporting the data.

The regional discussions about public reporting reflect broad national interest. Is the purpose to inform consumer choice, to drive improvement among providers, or a combination of the two? All NRHI members wish to have both purposes pursued in their regions, but their emphasis and methods vary. There is general recognition that the information should be delivered in varying formats and levels of detail depending on the audience.

Among the various stakeholders in regional collaboration, there is an ongoing tension between what consumers want and need, what purchasers want them to have, and what the physician community is willing to accept in the public arena.

“The NRHI organizations engaged in public reporting are attempting to drive improvement among those being reported on, while also encouraging consumers to focus on quality data and making the data user-friendly.”

Some argue that consumer response to data will not meaningfully impact quality improvement and therefore the emphasis should be on motivating institutional or provider change. There is agreement that some measurements are most (or only) valuable to the consumer at the individual

physician level, at least measurements of patient experience. Until data can be provided that will help the consumer choose a doctor, it may not be possible to assess the potential of publicly reported data to contribute to consumer activation. But some NRHI members are wary about physician-level data because it would undermine a program's emphasis on systems improvement rather than individual physician change.

In addition to the political considerations surrounding physician-specific data, there are methodological and cost issues. NRHI organizations all report difficulties achieving large enough sample sizes to report precise clinical outcomes at the physician level—although adding Medicare and Medicaid data would help for some measures. This issue will likely arise with efficiency data as well.

Data on patient experience at the individual physician level is costly, over \$1 million for each round of measurement in most markets, although only 40–45 responses per physician provides highly reliable data about performance according to psychometric research. In California, the cost for obtaining these data has been approximately \$175 per physician or \$7.8 million for the 45,000 physicians caring for most of the commercially insured and Medicare patients in the state.

In Massachusetts and California public reporting of group and practice-site data is focusing attention on improvement within the physician community. In California, the public reporting has been combined with reward for results. It is not clear whether the cost-benefit ratio would justify reporting these data for individual physicians, although consumer advocates and purchasers believe it would be more helpful to consumers in making healthcare choices. The physician community is resistant to this level of reporting. Therefore, the NRHI organizations engaged in public reporting are attempting to drive improvement among those being reported on, while also encouraging consumers to focus on quality data and making the data user-friendly.

Data Collection and Aggregation

As summarized in Table B, data collection and aggregation efforts vary. Some organizations use health plan claims data or physician-level HEDIS results, while others collect data directly from physician practices. There is also variation among the types of quality measures collected and the types of organizations targeted: health plans, hospitals, or physician offices. All organizations collect data on clinical measures, and some gather patient experience data. The collection of efficiency data is just beginning in a few organizations. Regardless of the approach used, two clusters of challenges have emerged as consistent themes across all organizations.

- **Adding Medicare Data to Commercial Databases.** All of the reporting organizations affirm the importance of integrating Medicare data into regional databases; however, with the exception of Minnesota, all have been relatively unsuccessful. There are two inter-related issues at play here. One stems from the long-standing regulatory requirements that classify information collected by Medicare as peer-protected. This means that a regional coalition could be measuring and reporting for a commercially insured population the same measures that CMS or its contracted Quality Improvement Organization (QIO) reports for the Medicare population in the same region; but the QIO data would be peer-protected. The other difficulty reported by most NRHI members is the local QIO's lack of interest in addressing this issue collaboratively.

However, MN Community Measurement developed a collaborative model with Stratis, the QIO in Minnesota, resulting in the successful joining of some Medicare data with data for commercial insurance products in some measurement activities. The QIO was able to obtain permission from CMS regional officials as well as medical groups—required to meet regulatory requirements for peer protection—to collect and report the data. The incentive for the medical groups was that the performance reported for their practices was made more representative of their actual patient populations by including Medicare data. Despite this successful effort, coalitions in other markets are skeptical about its application in their regions, since

permission would be needed from all medical groups and individual physicians and in many markets large numbers of physicians are in solo practice.

Fortunately, there will be an opportunity to address these challenges directly with CMS over the coming months. It was recently announced that all NRHI organizations doing public reporting were selected as pilot sites for the Ambulatory Care Quality Alliance (AQA) to implement clinical, patient experience, and efficiency metrics across an all-payer dataset, including Medicare data.

- **Defining and Incorporating Efficiency Metrics.** There is broad agreement that a metric of cost efficiency or resource utilization is an important component of the quality equation, but that the work is in its infancy. The NRHI coalitions are determining how best to incorporate these metrics into their data collection and reporting agendas. California and Massachusetts are farthest along in implementing pilot efforts to understand critical methodological questions around the validity and utility of efficiency metrics. The AQA performance measures committee is defining a standard metric by which to measure efficiency and resource utilization. As AQA pilot demonstration sites, NRHI organizations will remain active in the implementation and evaluation of these metrics.

Quality Improvement

There is no question that the public reporting of data among NRHI organizations is fueling interest in quality improvement among those being measured. One of the most critical goals of NRHI is to support improvement to healthcare delivery organizations. There are two key challenges: (1) cultivating and teaching medical leadership to do systems improvement and other quality improvement work; and (2) engaging a deeper level of commitment from practicing physicians. NRHI discussions and experiences point to the following insights in accomplishing these goals.

Engaging Senior Leadership

- **Develop the skills of key leaders.** Beyond cultivating engaged leaders, it is important to create opportunities for formal leadership training and coaching around quality improvement. This will lead to overall culture shifts. In Minnesota, for example, many groups have acquired talented, committed leaders as a result of engagement in the ICSI process for a number of years. ICSI runs topic-specific collaboratives on issues such as organizational change management and culture improvement.
- **Use visionary leaders as spokesmen to engage others.** Leaders who have had positive experiences in learning through regional coalitions can be encouraged to spread the word to other leaders who have not yet joined in.
- **Use peer pressure for engagement.** Both the Minnesota and Pittsburgh coalitions have CEO groups in which the CEOs from different organizations work together toward specific quality improvement aims.
- **Use media attention to increase public pressure to participate.** PRHI has developed relationships with key reporters, which has helped to engage CEOs who are concerned about their public image. The media contacts have conferred some public relations value when improving organizations are recognized for their leadership.

- **Make the business case for engagement.** It is useful to demonstrate through financial analysis that involvement is a good investment. Reward for performance is a vital element in making the business case for healthcare delivery organizations to improve processes and outcomes.

Engaging Practicing Physicians

- **Make doing the right thing the easiest thing.** Providing the tools to the practicing MD—especially those in smaller practices with more limited resources—is by far the greatest challenge for the regional coalitions.
- **Use professional networks to spread process improvements.** Networks of physicians and other professionals exist in all healthcare communities. Successes achieved by one or more members of a given network can be fostered in other members by making use of the pre-existing lines of communication and influence in these networks.
- **Bring the QIOs into the conversation.** The QIOs in the various markets have funding to provide quality improvement technical assistance, and they need to be engaged in the discussion about what the needs are for assistance and how best to meet them. In Minnesota, there is a strong working relationship between the QIO, Stratis, and the regional coalition partners, ICSI and MNCM. They routinely engage with Stratis on a variety of quality improvement initiatives.
- **Report data for quality improvement at both a group level and an individual physician level.** Group-level data engage the leadership and build a sense of accountability, ownership, and motivation to improve the whole system. Individual-level data engage the physician and dispel the notion that the problem lies elsewhere.

Financial Sustainability

NRHI coalitions receive funding primarily from foundation grants and from stakeholder organizations, using various cost-sharing arrangements. Cost-sharing takes the form of member dues and assessments tied to specific products and services. Some NRHI members are moving away from dependence on grants or charitable contributions, and toward initiative-specific funding from health plans as well as providers. This shift has engendered some tensions concerning its impact on operations and dynamics of the coalition and on the sustainability of this funding model.

“Some coalitions believe sustainability is supported by the shared benefits of broad-based collaboration, achieving consensus from multiple stakeholders at the table. As stated by one participant, ‘. . .we have the diversity of feedback, input, and the buy-in across the board. That’s valuable. Certainly the health plans could go to another entity, work among themselves, and do aggregate reporting, but they value the diverse input.’ ”

The concern is that when one segment of otherwise equal stakeholders in a coalition—health plans, for example—funds the work, the objectives of the organization as a whole could become skewed. In one scenario, the provider organizations could begin to view the coalition as being merely an agent for the health plans. As single-stakeholder groups take on the funding of activities, coalitions will need to make explicit distinctions between purchasing a seat at the collaborative table and purchasing specific products and services resulting from the coalition’s activities.

Some coalitions are moving toward financial approaches that more explicitly bring provider groups into the cost-sharing model. Even if the financial responsibility is not equally divided among all stakeholders, having everyone share a portion of the cost can diffuse the tension among all parties.

An original impetus for health plans to fund coalition activities was the ability to gain cost efficiency by pursuing some activities jointly, for example, conducting a single survey across plans or pooling data for reporting of performance measures. It has been difficult for some coalitions to sustain this funding over time. However, there is increasing employer demand for health plans to support medical group comparative performance reporting and improvement. This may induce health plans to continue contributing to coalition reporting activities.

The recently unveiled NCQA Quality Plus Program, while currently voluntary, is likely the first step toward adding measures of physician performance to the set of required elements for health plan accreditation. NCQA is offering certification to regional coalitions to collect and report these data on behalf of health plans, and has created a business case for health plans to engage by offering discounted fees when they work through coalitions. MHQP and MNCM are the first regional collaboratives to become “early adopters” of NCQA’s quality plus program.

On the provider side, pay for performance is likely to create demand for the work of the regional coalitions and bring physicians and hospitals to the table as both participants and financial supporters.

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Measuring Success of Coalitions

Evaluation of the coalitions is still in its infancy. Grant funders, consumers, payers, and participating stakeholder organizations—particularly the physicians and institutions whose performance is measured—all have a strong interest in evaluation. Some of these audiences are looking for a demonstrated return on their investments in coalitions.

A number of tools could be developed or refined to measure the success of regional coalitions systematically. These include:

- **Satisfaction survey of coalition members.** This type of instrument could be used at regular intervals to assess performance. Some NRHI organizations already conduct this type of survey or less formal canvasses of their members' satisfaction. ICSI has conducted formal member satisfaction surveys for over ten years.
- **Return-on-investment (ROI) analysis.** Coalitions are increasingly called upon to make the business case to organizations to secure continued participation and financing. A standardized template enumerating the qualitative and quantitative aspects of the ROI would be beneficial to regional coalitions that could then create a more tailored model to meet individual needs.
- **Formal research evaluation.** A more rigorous evaluation of the impact of regional coalitions would be useful in making the case for investment. The focus could be measures of healthcare processes, health outcomes, costs, or all three. Although evaluations of disease-specific collaboratives have been performed, there has been no formal evaluation of the effectiveness of a regional coalition. The undertaking would be methodologically difficult and expensive, but the findings would help determine whether regional coalitions are truly effective and to what degree.

Regional Coalitions as Participants in the National Arena

Several initiatives are underway to establish quality measurement and improvement programs at the national level. The IOM in its recent report *Performance Measurement: Accelerating Improvement* called for the establishment of a National Quality Coordination Board to set and oversee national goals for improvement and measures for evaluating performance. The Ambulatory Care Quality Alliance (AQA) has proposed a National Stewardship Board to set national standards for measurement and reporting of performance data. The Care Focused Purchasing (CFP) initiative seeks to bring together employers and insurers to create nationally aggregated performance data. CMS has introduced a pay-for-performance program for hospitals and is developing one for physicians. The Robert Wood Johnson Foundation has introduced its Aligning Forces for Quality initiative to support quality improvement in selected metropolitan areas using a standardized model for community organizations.

“Regional coalitions bring key local conditions and sensitivities into quality measurement and reporting. . . regional coalitions are in the best position to create data collection and aggregation platforms, organize incentive arrangements, and provide support for improvement action among providers in their areas.”

Although consensus is growing that healthcare improvement goals and measures should be established and overseen nationally, the above initiatives allow for the strong participation of regional coalitions. The national structures will need formal mechanisms for feedback, and regional organizations are in the best position to create data collection and aggregation platforms, organize incentive arrangements, and provide support for improvement action among providers in their areas. Specifically, regional coalitions bring key local conditions and sensitivities into the following areas of quality measurement and reporting:

“By serving as regional nodes for discussions with national programs, coalitions will facilitate the smooth coordination of regional and national strategies.”

Gathering and reporting data. As AQA pilot sites, NRHI organizations lead the nation in data collection, aggregation, and reporting methods, and are natural vehicles for the establishment of mechanisms to connect electronic medical records and make them interoperable. Coalitions could participate in national initiatives by becoming Regional Health Information Exchanges.

Developing incentive arrangements. Effective processes include the local health plans as participants and take local payment models into account. California’s Integrated Health Association provides a good example of establishing congruity across different payers based on rewards for high performance by hospitals, medical groups, and physicians. As required by anti-trust law, it avoids questions of payment amount or any coercion of payers.

CMS and some national insurers, including Aetna, are beginning to pay for results on a national basis. As CMS develops proposals for national initiatives, regional coalitions that have expertise in coordinating pay for performance in their areas can provide valuable insights. By serving as regional nodes for discussions with national programs, coalitions will facilitate the smooth coordination of regional and national strategies.

Providing technical assistance for hospitals, medical groups, and physicians.

In addition to helping with the mechanics and statistics of process improvement, assistance should help with leadership improvement and with cultural and organizational change to enhance quality improvement. All of these areas require knowledge of local culture and history.

Medicare’s Quality Improvement Organization (QIO) program “provides a potentially valuable nationwide infrastructure dedicated to quality healthcare,”^k according to a 2006 IOM report. The IOM proposed several changes to improve the QIO program:

1. Work done under QIO contracts should be narrowed to focus primarily on technical assistance for quality improvement.
2. Non-physician experts in quality improvement should be added to the boards of organizations with QIO contracts, to end physician domination.

“. . .having a voice in the creation of national programs provides an incentive for the establishment of regional coalitions.”

3. Adjudication of Medicare enrollee complaints should be removed from the work of organizations with QIO contracts and handled in a separate program.
4. CMS should provide clear goals in its contracts, rather than dictating the internal operations of the organizations doing the work.
5. Organizations should be permitted to sell their quality improvement services in the states for which they have QIO contracts.

If these proposals are embraced by CMS, most regional coalitions that provide technical assistance would be eligible to hold QIO contracts directly from CMS or to sub-contract with QIOs in their states to perform some functions. Such arrangements could improve the responsiveness to regional circumstances and provide base-level funding for technical assistance in many regions.

Unfortunately, CMS has a long history of vaguely stated goals and micro-management of its contracted QIOs. Nonetheless, a collaboration between CMS and regional coalitions could benefit Medicare enrollees as well as the population as a whole. Even absent a direct relationship between CMS and regional coalitions, productive partnerships between regional coalitions and QIOs remain possible and desirable.

The Federal Reserve provides a model for how a national program could be implemented to fit regional circumstances. Its national monetary policy is put into practice by the Federal Reserve Districts. By analogy, national healthcare improvement initiatives could be implemented by regional healthcare coalitions. For example, quality measures could be established at the national level along with principles and procedures for aggregating regional data. The results could be reported in each region and forwarded to a national reporting hub.

It is unrealistic to expect that the whole country will become organized into regional coalitions in the foreseeable future; some regions do not have the requisite marketplace conditions, and some have alternative structures in place. Nonetheless, the prospect of having a voice in the creation of national

programs provides an incentive for the establishment of regional coalitions. A national association of regional coalitions could provide valuable assistance in such efforts.

It makes sense to bring together regional coalitions that are doing similar work, and NRHI was formed for this purpose. In the future it may be useful to make it a more formal organization, possibly following the model of the National Business Coalition on Health. The establishment of a legal entity may be helpful in securing funds and assuring permanence.

NRHI potential roles in a national framework could include:

- Partnering in the development of healthcare improvement aims and measures;
- Providing a collective voice for regional coalitions;
- Helping develop programs for technical assistance, electronic interchange, and reward for results; and
- Fostering communication of knowledge of national programs at the local level.

Inadequate or unstable funding for regional coalitions remains a problem, although many funding strategies have been tried. Moving toward a national scope will require significant funding that—at least during the initial phase—will exceed contributions available from existing NRHI organizations.

Next Steps

“The promise of regional coalitions for healthcare improvement is that they can provide a local focus for energies for improvement and respond quickly and accurately to local circumstances.”

Convinced of the value of NRHI, the members seek to form a more durable organization with four purposes:

- Establishing a collective voice for dialogue with CMS, AHRQ, NCQA, and other national entities such as Care Focus Purchasing and Bridges to Excellence;
- Assuring communication among regional coalitions on national initiatives and other topics of common interest;
- Sharing best practices among regional coalitions for healthcare improvement; and
- Providing assistance to emerging regional coalitions.

NRHI is seeking funding to hire a coordinator to lead the effort and to handle a number of management functions:

- Establish connections with key decisionmakers within CMS and other national quality improvement bodies;
- Extend NRHI’s communication beyond conference calls and occasional meetings;
- Foster opportunities for partnering with QIOs;
- Develop means for assisting new coalitions; and
- Lead the development of criteria for NRHI membership and work to increase membership.

NRHI is also seeking funds that will be used to evaluate coalitions’ programs, conduct ROI analyses, and assess the effectiveness of regional coalitions in improving healthcare.

The promise of regional coalitions for healthcare improvement is that they can provide a local focus for energies for improvement and respond quickly and accurately to local circumstances. At the same time, they can play a role in the formation and execution of national quality endeavors. Through their deep understanding of local facts on the ground, they can move national and regional efforts to improve healthcare.

Table A: Program Elements of NRHI Member Coalitions

Market or Coalition	Public Reporting	Quality Improvement*	Pay for Performance	Local Health Information Exchange
California (particular programs coordinated by or with the Pacific Business Group on Health)				
California Cooperative Healthcare Reporting Initiative (CCHRI)	<ul style="list-style-type: none"> Health plan HEDIS Health plan CAHPS Consumer Assessment Survey (CAS) report of patient experience at medical group level 			
Integrated Healthcare Association (IHA)	<ul style="list-style-type: none"> Medical group level clinical measures Medical group level IT infrastructure measures 		Pay for Performance initiative based on medical group level clinical, patient experience, and IT measures.	
Breakthroughs in Chronic Care Program (BCCP)		Improvement programs geared toward redesigning care at the practice level. Areas of focus are around IHA Pay for Performance measures.		
Massachusetts				
Massachusetts Health Quality Partners (MHQP)	<ul style="list-style-type: none"> Medical group level clinical measures (based on HEDIS) Patient experience measures at practice site level 	Developing and disseminating collaborative guidelines and quality improvement tools.	RWJF grantee for Rewarding Results to evaluate the impact of health plan financial incentives on physician performance.	Coordinate with Massachusetts Regional Health Information Organization (RHIO) for quality information.
Minnesota				
Institute for Clinical Systems Improvement (ICSI)		<ul style="list-style-type: none"> Development and maintenance of clinical practice guidelines Improvement programs and assistance for medical group and hospital members (58 medical groups and hospital systems), including formal training, educational conferences, coaching, and collaboratives (e.g., diabetes, culture improvement) 		Development of standards for transmission of referral information.
MN Community Measurement (MNCM)	<ul style="list-style-type: none"> Medical group level clinical measures 		Diabetes results used by health plans and local employers for Pay for Performance programs.	
Pittsburgh				
Pittsburgh Regional Health Care Initiative (PRHI)		Perfecting Patient Care (PPC) methodology for care redesign at the point of care, focusing on chronic disease management, cardiac surgery, child development, and long term care issues.	Initial program and countermeasure development for Pay for Performance programs funded by insurers.	
Wisconsin				
Wisconsin Collaborative for Healthcare Quality (WCHQ)	<ul style="list-style-type: none"> Medical group level clinical measures based on WCHQ “bottom-up” methodology Hospital efficiency measures Health plan HEDIS Health plan CAHPS Hospital JCAHO/CMS measures 	<ul style="list-style-type: none"> Support informal best practice sharing and improvement collaboration through monthly meetings, conference calls, and Internet Support formal improvement collaboratives (e.g., cardiac care, breast cancer care) Host an annual Fall Forum where best practices are shared 		

* Achieving agreement on topics in evidenced-based medicine; Technical assistance for improvement

Table B: NRHI Data Collection and Aggregation Approaches

Market or Coalition	Type of Measures Collected	Data Source/Data Collection Level	Internal Reporting Level	Public Reporting Level
California				
California Cooperative Healthcare Reporting Initiative (CCHRI)	Health plan HEDIS	Coordinated office chart review plus administrative data	Health plan	Health plan
	Health plan CAHPS	Single survey vendor for all plans plus additional questions	Health plan, physician organization for the additional questions	Health plan
	Physician organization level patient experience	Single survey vendor for physician organizations	Physician organization or regions within physician organization	Physician organization or regions within physician organization
	Physician level patient experience	Single survey vendor for physician organizations selecting physician level survey	Physician	
Integrated Healthcare Association (IHA)	Physician organization clinical measures	Administrative data from plans and physician organizations	Physician organization or regions within physician organization	Physician organization or regions within physician organization
	Physician organization IT/systems measures	Physician organization self-reports via web-based survey tool	Physician organization or regions within physician organization	Physician organization or regions within physician organization
Massachusetts				
Massachusetts Health Quality Partners (MHQP)	HEDIS measures on clinical quality	Health plan data files	Physician, practice site, medical group, physician organization	Practice site, medical group, physician organization
	Patient Experience with primary care using the Ambulatory Care Experiences Survey (ACES)	Surveys at the physician level	Physician, practice site, medical group, physician organization	Practice site, medical group, physician organization
Minnesota				
Minnesota Community Measurement (MNCM)	Health plan HEDIS	Administrative data plus office chart review	Medical group	Medical group
Wisconsin				
Wisconsin Collaborative for Healthcare Quality (WCHQ)	Ambulatory clinical process measures	Reported by physician groups	Individual provider	Physician group
	Ambulatory clinical outcome measures	Reported by physician groups	Individual provider	Physician group
	HEDIS measures on clinical quality	Health plans	Physician group	Health plan
	CAHPS (patient experience)	Health plans	Physician group	Health plan
	JCAHO/CMS clinical quality measures	Hospitals	Hospital	Hospital
	Leapfrog safety measures	Hospitals	Hospital	Hospital

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