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When Regional Health Improvement Collaboratives and States Work Together:

Lessons Learned from Health Improvement Partnerships

Introduction

Today, there are a host of new opportunities to advance delivery system and payment reform.

- At the federal level, policies, programs, and funding have coalesced around a common national vision based on the Triple Aim of better care, better health, and lower costs. Medicare has advanced significant payment reforms for accountable care organizations, primary care, and bundled payments. Technical assistance and financial resources—State Innovation Model (SIM) awards and innovation grants—have been provided to states, providers, and others to test and implement broader reform models.
- States have advanced significant reforms through their Medicaid programs, with an increased focus on broader population-based initiatives and measures.
- Employers are adopting value-based purchasing strategies working with third-party administrators and carriers or directly with health systems and providers.

While there has been a major push for health care innovation within each of these sectors, the challenge seems to be how to foster productive partnerships across sectors. Effective changes that affect broad populations and delivery systems require coordination of policies and technical capacity. What should be the focus of improvement? What incentives will be created? How can progress be measured consistently using transparent methods of data collection and analysis? What investments are needed to strengthen care management and population health monitoring? In the absence of a single organization or authority, how are priorities established, resources allocated, and policies instituted to advance in a common direction?

State government health care leadership needs to support this coordinated approach, and states need strong partners to develop and advance specific strategies for health care transformation on the ground. The work of regional health improvement collaboratives (RHICs) is aligned with national and state policy goals and introduces opportunities to strengthen governance and technical capacity to support new models. RHICs have been established around the country as nonprofit, multi-stakeholder organizations made up of local health care, businesses, and community leaders.

What is a Regional Health Improvement Collaborative (RHIC)?

An RHIC has three characteristics:

1. An RHIC is a nonprofit organization in a specific geographic region of the country (i.e., a metropolitan region or state);
2. It is governed by a multi-stakeholder board comprised of health care 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
3. An RHIC helps the stakeholders in its community identify opportunities for improving the health and health care of the community and facilitates planning and implementation of strategies for addressing those opportunities.

They work directly with providers, provider organizations, commercial payers, employers, consumers, and other relevant stakeholders to build consensus on strategies and techniques to improve health outcomes and reduce health spending.

In other words, states and RHICs have the potential to collaborate. To foster that opportunity, eight state governments and their local RHICs were brought together in March 2015 by the Milbank Memorial Fund and the Network for Regional Healthcare Improvement to explore how closer collaboration between state and regional efforts could help advance mutual health care improvement goals.

This paper was developed by the Milbank Memorial Fund and the Network for Regional Healthcare Improvement to document the experiences of selected states and RHICs that established formal partnerships designed to advance and accelerate shared aims—with a specific focus on cultivating more effective use of health care data. Why are these partnerships focusing on data? It is impossible to measure health care performance without robust data. Having comprehensive data depends on the contributions, collaboration, and cooperation of a broad array of stakeholders. In addition, the use of data requires agreement on the ground rules for its use, which necessitates building trusted governance and operating models. Finally, working with health care data is resource-intensive, and creating these partnerships can leverage infrastructure and resources to make data available in more effective and efficient ways. The case studies described in this issue brief highlight specific benefits and challenges associated with these activities.

State-RHIC Teams at the Collaborative Leadership Meeting

COLORADO:
Colorado Office of the Governor; Colorado Department of Health Care Policy and Financing; and Center for Improving Value in Health Care

LOUISIANA:
Louisiana Department of Health and Hospitals; Louisiana Bureau of Health Services Financing (Medicaid); and Louisiana Health Care Quality Forum

MASSACHUSETTS:
Center for Health Information and Analysis; Massachusetts Health Quality Partners; and Massachusetts Health Policy Commission

MINNESOTA:
Institute for Clinical Systems Improvement; Minnesota Community Measurement; Minnesota Senate; and Minnesota Department of Health

NEW YORK:
United Hospital Fund and Finger Lakes Health Systems Agency

OREGON:
Oregon Health Care Quality Corporation and Oregon Health Authority

UTAH:
HealthInsight and Utah Department of Health

WASHINGTON:
Washington Health Alliance; Washington State Health Care Authority; and Whatcom Alliance for Health Advancement

Why Focus on State RHIC Partnerships for Improved Health Care Data Use?

Why focus on this particular relationship? Through Medicaid, public purchasing, and regulation, states have become instrumental in driving improvements in health care quality and affordability. But good, reliable information is critical for improvement, and this data resides with many payers and providers. States' capacities to collect, analyze, and use data are often limited, so they need partners to coordinate and provide these activities. RHICs can offer direct engagement with these stakeholders and bring important technical skills to building data infrastructure and using data to redesign and evaluate care delivery and payment models.

Claims are one type of health care data. Many states have developed state-based all-payer claims databases (APCDs) as a way to collect and manage data to inform purchasing and improvement and to educate the public about variations in health care cost and quality. States are beginning to use these data sets in different ways. Many are advancing transparency and public reporting by creating a shared understanding of the cost and quality of the health care they are purchasing.

However, to achieve their full potential, APCDs need to define specific use cases that relate to specific health care problems—avoidable readmissions or emergency department (ED) use, for example—and they need to address the needs of users who are on the front lines of health care innovation. Some states are addressing these needs and accelerating exchange of information by partnering with external entities that have: (1) multi-stakeholder governance models that develop and enforce policies across the community and (2) technical expertise in data management and use.

What do RHICs have in terms of health care data use that states can benefit from? RHICs, which have local or regional relationships, facilitate multi-stakeholder convenings that include health plans, providers, consumers, and payers. They also may provide states with other critical capabilities to advance reform, particularly in terms of data collection, aggregation, analysis, and use. Many RHICs have developed multi-payer claims databases that provide a more complete picture of health care performance across a given region or state. These models vary widely: some RHICs are selected or contracted to serve as the APCD in the state, while others develop and maintain separate data sets, and still others use data from a state's APCD. Many RHICs have clinical data and direct partnerships with providers who use the data to change care delivery. Some of the RHICs have experience using these data sources for publicly reporting cost and quality performance information; for engaging employers and the public in using the results; for leading quality improvement initiatives; for informing and driving payment reform efforts; and for advancing population health efforts.

Partnerships are easy in theory and hard in practice. It takes dedicated leadership and time to build trust among the competing interests of different groups. This issue brief illustrates the opportunities and challenges in developing successful state/RHIC partnerships. The questions addressed in this paper include:

> How are these collaborations formed?
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> How are they managed and sustained?
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> Ultimately, what impact do they have on achieving the Triple Aim for health system improvement?

Because many other states and regional organizations are exploring similar issues, it is expected that the case studies will help inform the efforts of others; in particular, state policy leaders who are committed to local health care improvement, including those from the executive and legislative branches, as well as operational staff running state programs and data systems. In short, these examples of partnerships can save time and resources and increase the likelihood of success as others take on this work.

Overview of the Case Studies

The case studies presented below illustrate ways in which state governments and RHICs are working together in Massachusetts, Colorado, Louisiana, and Oregon—all with a particular focus on data issues. The case studies showcase key lessons for public/private collaborations using data and analytics to drive the transformation of health care delivery and payment.

By working at the state and regional level, data-driven health improvement initiatives can better identify, respond to, and meet the needs of their local communities. Through public-private partnerships, the levers of the state—purchasing, regulation, and policy—may be aligned with private-sector leadership and innovation and on-the-ground technical resources. Although each state and RHIC has unique contexts and challenges, these case studies offer ideas for other states. A summary of key themes follows the case studies at the conclusion of the paper.

Case Study #1

State of Colorado and the Center for Improving Value in Health Care

This case study provides an example of strong state leadership and commitment to advancing multi-stakeholder collaboration and partnership, specifically focused on data analytics stimulated by a legislative mandate for data collection and reporting through an RHIC.

The Team

- **Colorado's Office of the Governor** provides the state's vision and leadership for health care—the state consistently is ranked by various polls as one of the healthiest (with low rates of obesity and inactivity) in the nation. The office oversees the state's Health Information Technology (HIT) Coordinator Office and its SIM test award. HIT is an integral component of health transformation initiatives in the state, including SIM, which is focused on integrating physical and behavioral health care as well as public health. The office is committed to a robust HIT strategy that works across all initiatives and partners, including communities, providers, payers, public health, and other stakeholders. The state's vision is focused on integration and collaboration among stakeholders, leveraging existing building blocks within communities, and aggregating information across payers.

- **Colorado's Department of Health Care Policy and Financing** is the single state agency administering Colorado Medicaid and the Child Health Plan Plus program. The department has a budget of more than $7 billion and includes the Health Information Office, which is responsible for developing strategies for systems development and operations for client eligibility, health care claims processing, and HIT on behalf of the department.

- **The Center for Improving Value in Health Care (CIVHC),** is a nonprofit RHIC whose mission is to inform, cultivate, and advance strategic initiatives that improve care, contain costs, and advance the health of Coloradans. CIVHC administers Colorado's APCD, offering a comprehensive picture of health care cost, quality, and utilization based on claims data from government and private payers alike. CIVHC serves no single-interest group and works with any party in Colorado interested in playing an informed role in advancing health care value including providers, employers, payers, consumers, policy makers, government agencies, researchers, and health care advocacy organizations.

Lessons Learned

Colorado has been a national leader in the rapid development of a robust APCD, which supports both public reporting and transparency and Health Insurance Portability and Accountability Act (HIPAA)-permitted research, public health, and health care operations uses. By contracting that function to a private, nonprofit entity, technical and business resources have been available that may not have existed within state government. The multi-stakeholder governance structure of CIVHC ensures active engagement of Colorado's data users. Two examples of state-RHIC partnership are described below.

All-Payer Claims Database: In 2010, the state passed legislation creating a state APCD and establishing several required actions and milestones. CIVHC was appointed the APCD administrator, working closely with a legislatively mandated APCD Advisory Committee to develop a plan to successfully meet the statutory milestones. As the state's APCD administrator, CIVHC provides state agencies, including Medicaid, public health, and the Department of Insurance, with data sets that are analyzed to support various initiatives and programs. As an RHIC, CIVHC has led implementation of cost reporting for the state, including participation in a national pilot program that produces commercial total cost of care and resource use results and shares those results with primary care provider groups. By specifically giving CIVHC this work, the state legislation has accelerated cost reporting.

The Health Professional Workforce Masterfile: Few states have comprehensive data on the characteristics of various categories of health care professionals, yet planning for and assessing population health models is highly dependent on the availability and mix of appropriate health care personnel. This information could include type of license or certification, as well as specialties, location of practice sites, and participation in health plans. To plan for existing and future health professional workforce needs in Colorado, adequate data about where clinicians practice and how they practice is essential. In light of recent coverage expansions—associated with the Affordable Care Act and with quality improvement, payment, and delivery system redesign initiatives—the state and many stakeholders would benefit from access to complete, accurate, and timely information regarding the Colorado health care workforce. Unfortunately, there is currently no reliable, comprehensive data set that can fully meet these and other CIVHC core health workforce data needs. Existing data sets that provide such insights lack a reliable, real-time capacity to present a comprehensive picture of the current state of the Colorado health care workforce relating to population health needs (i.e., access for newly insured populations, availability of patient-centered medical homes, etc.).

Participants in Colorado's Health Professional Workforce Data Consortium

- Colorado Department of Public Health and Environment (CDPHE) – Lead agency
- Colorado Department of Health Care Policy and Financing – State Medicaid agency
- Colorado Department of Regulatory Agencies (DORA)
- Center for Improving Value in Health Care (CIVHC) – Colorado APCD administrator
- Colorado Regional Health Information Organization
- University of Colorado Denver School of Medicine
- The Colorado Medical Society
- Representatives of many Colorado health policy organizations, physician and non-physician provider organizations, and consumer advocacy groups

To help address this lack of information, and with strong leadership from the governor's office, the Colorado Department of Public Health and Environment (CDPHE)[1] established the Health Professional Workforce Data Consortium. The ultimate goal of the consortium is to create a Health Professional Workforce Masterfile that provides comprehensive, valid, and reliable provider information to satisfy the needs of a wide variety of Colorado stakeholders, such as health plans, providers, and community health organizations. Success will require the active participation and input of all interested Colorado health care stakeholder groups.

Sources of health care workforce data fall into two categories: public and private. Publicly available data, such as Colorado's Department of Regulatory Agencies (DORA) licensure data, the National Provider Identifier data set, and the National Center for Health Workforce Analysis Area Health Resource File, can be accessed free of charge and/or requested

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[1] Although neither CDPHE nor DORA attended the March 2015 meeting, they are integral to the consortium. The Office of the Governor, the Department of Health Care Policy and Finance, and CIVHC work in close collaboration with both agencies on the Masterfile initiative.

online. Private sources of data, such as the American Medical Association Physician Masterfile, Colorado APCD, and other vendor-supported master files, are available for purchase. Given the unique strengths and limitations of existing data sets, the ability to access data from multiple sources is necessary for purposes of record matching, data completeness, and overall validation.

Work on a prototype of the Colorado Health Professional Workforce Masterfile has been ongoing through 2015 and is expected to include an extract from the Colorado APCD provider file that will be merged with DORA licensure data available through the CDPHE Primary Care Office. Development of the prototype will confirm the integration, validation, de-duplication, and data cleaning requirements that will be necessary to successfully secure and integrate additional data sets. Thus, the initiative is laying the foundation to more efficiently and effectively manage and aggregate other data sources in the future. Prototype development will also include generation of high-level business requirement documents that will serve as a blueprint for master file development and ongoing operations.

Partners in the consortium are grouped into categories that are important in establishing agreements that govern the acquisition, exchange, and utilization of data. Input organizations possess primary sources of data that can directly contribute to a comprehensive health care workforce database. Output organizations do not possess actual data but access this information to produce information about health care system dynamics and workforce capacity that informs health policy change. In some cases, organizations may fall into both the input and output categories. Physician and nonphysician organizations, consumers, and advocacy groups in local communities inform the consortium about regional priorities and needs, which influences input and output needs.

In summary, a key takeaway from the Colorado case study is that a state can model the multi-stakeholder behavior it wants to foster integration of information and collaboration with all stakeholders. As the Masterfile is created, the state will use a multi-stakeholder approach to decide the governance structure, determine who has access to information, establish data release policies, and more.

Case Study #2

State of Louisiana and Louisiana Health Care Quality Forum: Louisiana's Emergency Department Information Exchange

The Louisiana Department of Health and Hospitals (DHH) has a policy goal of reducing overuse of hospital emergency departments but needs information on utilization patterns for effective intervention. The Louisiana Health Care Quality Forum, an RHIC, has a robust health information exchange (HIE) with the ability to connect provider systems and capture real-time utilization information for feedback and improvement. With state support, participation in the HIE has been expanded to ensure the most robust data capture to inform providers and the Medicaid program. This case study from Louisiana is particularly effective in demonstrating the direct benefit of a formal partnership to both the state and the RHIC.

The Team

- **Department of Health and Hospitals** is the state agency designated to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of Louisiana.

Examples of Ways that Medicaid Agencies and RHICs Can Partner Using Data

1. Evaluate patient-centered medical home programs;
2. Benchmark Medicaid plan performance against commercial plan performance;
3. Measure and compare disparities across public and private payers and discuss how to address the gaps;
4. Calculate pay-for-performance incentive payments;
5. Create churn reports for the state to identify patients' previous and current plans and providers; and
6. Analyze bundled payments for public versus private payers.

- The **Bureau of Health Services Financing**—the Medicaid agency—is part of DHH and leverages its contracting and purchasing power to advance delivery system and payment reform.

- **Louisiana Health Care Quality Forum:** Louisiana Health Care Quality Forum is a private, not-for-profit RHIC dedicated to leading evidence-based, collaborative initiatives to improve the health of Louisiana residents. Established by the state legislature in 2007 in the wake of Hurricanes Katrina and Rita, the Quality Forum serves as a neutral convener, bringing together providers, payers, purchasers, and consumers to plan, promote, and drive quality improvement strategies in Louisiana. As the state-designated entity for Louisiana's health IT initiatives, including the state's Regional Extension Center and the statewide HIE, the Quality Forum is the administrator of the state's HIT infrastructure.

Lessons Learned

As the state's HIE, the Quality Forum is able to support the state in delivery system transformation, and the state is able to leverage its contracting decisions to support a robust HIE. This synergistic relationship is described below.

Leveraging State Purchasing Power to Strengthen the HIE: The state's HIE was established in 2011 with two pilot sites. Over time, it has grown to include more than 240 hospitals, health care providers, school-based health centers, home health companies, and other health care-related entities. In 2015, the HIE housed nearly 3.8 million unique patient records, processed nearly 80 million transactions per month, and featured a number of core and value-added services, features, and functionalities.

The effectiveness of the HIE as a tool (including its ED component described below) is contingent on the robust participation of hospitals and other providers. Recognizing this relationship, Louisiana Medicaid included in its health plan contracts a provision that requires at least 75% of a plan's participating EDs to subscribe to the HIE, which in turn helps the Quality Forum develop and administer HIE applications that will be useful and valuable to providers. The state notes that the 75% requirement will be increased over time at contract renewal.

Designing a Data Application to Reduce Inappropriate ED Utilization: Louisiana, according to the Kaiser Family Foundation, is 45th in the nation in number of ED visits. Additional data from the Louisiana DHH ranks the state third in the country in per capita ED utilization with 511 ED visits per 1,000 population at an average cost of $1,000 per visit. The financial impact of the nonemergency use of EDs is significant: in fiscal year 2014, the Louisiana Medicaid program spent approximately $168 million on hospital payments for ED visits, and the DHH estimates that $70 million of that amount was for nonemergency conditions that could have been better and more efficiently treated in a primary care setting.

Recognizing the significant cost of providing primary care in an ED setting, Senator David Heitmeier sponsored Senate Resolution 29 in 2014, tasking the DHH with creating and leading a multi-stakeholder work group to address the use of EDs for primary care. The Emergency Room Reform Committee was established and began gathering and using data to identify trends that lead patients to the ED and developing strategies to reverse those trends.

In response to the recommendations of the Emergency Room Reform Committee, the DHH has established the Louisiana Emergency Department Information Exchange (LaEDIE), a health information exchange application that will receive and compile ED utilization data for Medicaid patients from the state's hospital EDs.

The Louisiana Health Care Quality Forum, operating as the state's HIE, developed and will run LaEDIE. Starting in the fall of 2015, each time a Medicaid patient visits an ED, an admit, discharge, transfer message is created and routed daily to the appropriate Bayou Health Plan, their Medicaid managed care plan. Along with the facility name, date, and time of visit, the message includes the patient name, chief complaint, and diagnosis.

Using this data, Bayou Health Plans can identify ED "super-users," patients who have had three or more ED visits in 90 days. The Bayou Health Plans can then conduct direct patient education and outreach efforts to instruct Medicaid patients in the appropriate use of EDs, to identify the causes that sent patients to the ED, to implement case management strategies to reduce the likelihood that patients will return to the ED for nonemergencies, and to assist patients in scheduling follow-up care with primary care physicians. LaEDIE will also enable health care providers in the EDs to access and review information about these patients' previous ED visits to enable quality and continuity of care.

State contract provisions that require hospital participation in the HIE ensure that all partners benefit from meaningful information sharing across the community. This not only helps Medicaid better manage the care of its members for better outcomes at a lower cost, it creates a strong business case for data exchange through a trusted partner. The DHH and the Quality Forum have partnered to achieve multiple shared objectives: enabling better care management, driving support to the state's HIE, and demonstrating the value of the state's investment in HIT through an effective program to reduce inappropriate ED utilization. The Quality Forum has a strong partner in the state, whose support provides sustainability and growth opportunities.

Case Study #3

Commonwealth of Massachusetts and Massachusetts Health Quality Partners

Massachusetts has led national efforts in coverage and payment reform and has developed rich data resources and a strong focus on transparency to guide that work. In addition, the state has led most data collection and reporting efforts in cost, utilization, hospital quality, and other key performance metrics, while Massachusetts Health Quality Partners (MHQP), the RHIC, has established itself as the leading source of physician quality and patient experience data. The Massachusetts case study illustrates benefits of state-RHIC coexistence and also the challenges that can arise between states and RHICs when responsibilities overlap.

The Team

- The **Center for Health Information and Analysis (CHIA)** is an independent, legislatively mandated, state agency that is the agency of record for Massachusetts' health care information. Its mission is to serve as a responsible steward for sensitive and confidential data and to report objective, reliable, and meaningful information about quality, affordability, utilization, access, and outcomes of the Massachusetts health care system. CHIA is the home of the Commonwealth's all-payer claims database, hospital discharge data, and financial and cost reporting, as well as reporting on key features of payment and delivery reform such as alternative payment methods.

- The **Massachusetts Health Policy Commission (HPC)** is a legislatively mandated, independent state commission tasked with bringing health care spending growth in line with growth in the Commonwealth's economy. The HPC analyzes and reports on cost trends through data examination and public hearings and promotes and invests in innovative delivery and payment models. The HPC is charged with increasing transparency of provider organizations and assessing the impact of market changes on the cost, quality, and access of health care services in Massachusetts.

- The third team member is **MHQP,** an RHIC. It is a broad-based coalition of physicians, hospitals, health plans, purchasers, patient and public representatives, and academics who have been working together for 20 years to promote improvement in the quality of health care services in Massachusetts. MHQP's mission is to drive measurable improvements in health care quality, patients' experiences of care, and use of resources in Massachusetts through patient and public engagement and broad-based collaboration among health care stakeholders.

Lessons Learned

For the past few years, these state agencies and MHQP have coordinated activities where they share overlapping priorities and visions and where they have duplicative responsibilities. In some instances, state regulations have been barriers to partnership.

The All-Payer Claims Database: The Massachusetts All-Payer Claims Database (MA APCD) is the most comprehensive source of health claims data from public and private payers in Massachusetts. With information on the vast majority of Massachusetts residents, the MA APCD promotes transparency and affords a deep understanding of the the state's health care system. It is used by health care providers, health plans, researchers, and others to address a wide variety of issues, including price variation, population health, and quality measurement. The CHIA's enabling statute allows for the collection of data from commercial payers, third-party administrators, and public programs (Medicare and MassHealth, Massachusetts' Medicaid program). These data come both from medical insurers and from specialty insurers and administrators of "carved-out" services, including pharmacy, mental health/chemical dependency, dental, and vision. The HPC is a primary user of the MA APCD for cost trends research and analysis of changes in the health care marketplace. It works closely with CHIA to support ongoing development and enhancement of the MA APCD.

MHQP has worked with Massachusetts' health plans and a broad multi-stakeholder group comprised of physician organizations, employers, and consumers to conduct a statewide practice pattern variation analysis (PPVA) using the MA APCD. The goal of the PPVA is to engage providers to reduce unnecessary or unexplained variation in medical and surgical practices that leads to overutilization and underutilization of services, higher resources use, higher costs, and lower quality. MHQP's PPVA program supports both the HPC's and CHIA's quality and cost containment goals for the Commonwealth. MHQP used health plan claims data from the MA APCD to identify high-cost, high-volume procedures with the greatest variation in practice. To do this work, MHQP paid CHIA to use data from the MA APCD and to apply an episode grouper. By sharing data with MHQP for performance variation analysis and quality improvement initiatives, the existing data set is being leveraged in new and important ways that are consistent with policymakers' aims. MHQP also has trusted relationships with providers that foster different types of engagement than that of the state but that complement the state's objectives.

As part of the Massachusetts SIM award, CHIA contracted with MHQP to engage with the provider community to document business requirements for a possible provider portal to the MA APCD. Over 120 physicians provided direct input to an initial exploratory survey, in-person meetings, webinar discussions, or a comprehensive broad-based survey.

Reporting to Providers, Payers, and Consumers: Both the HPC and CHIA have statutory responsibilities to report to the public on performance of the health care system. Each agency issues periodic reports that include utilization, cost, price, financial, quality, and access information. MHQP has a long history of developing and reporting on quality performance of physician practices, an area where the Commonwealth has historically had limited reporting capability.

MHQP is the only independent organization in Massachusetts that collects and publicly reports information about the patient experience, currently for commercially insured patients only. The Massachusetts Office of Medicaid has recently commissioned another vendor to field a patient experience survey for MassHealth members. MHQP began conducting its statewide patient experience survey in 2005 and has been publicly reporting its results since 2006. Recognizing the value of the patient experience information, which is part of the Standard Quality Measure Set that CHIA oversees, CHIA contracted with MHQP to provide partial funding for the statewide survey in 2014. The HPC has also licensed MHQP's statewide survey results for its analysis of statewide cost and quality trends. However, state support for MHQP's Patient Experience Survey has been a year-to-year decision, which contributes to uncertainty about the sustainability of the survey. Data-use limitations imposed by the RHIC have also presented challenges to the utility of the data for the Commonwealth. There is an opportunity for the state to develop an ongoing plan and funding model to ensure long-term access to statewide patient experience information.

Provider Registration: As part of the recent Chapter 224 legislation, the HPC and CHIA were directed to develop and administer a registration program for provider organizations. As part of the registration process, the provider organizations, as defined by the law, must submit information on their organizational and operational structures and governance. The goal is to have a centralized database of providers to further the HPC's and CHIA's ability to analyze health care quality, cost, and other outcomes at the provider level and to understand the interrelationships of providers with one another.

MHQP has invested significant time and resources in developing a Massachusetts Provider Directory that is the foundation of MHQP's performance and reporting work. MHQP's directory has some—but not all—of the data elements that will be required by the Commonwealth for the provider registration program. As the Commonwealth advanced its provider registration objectives, it has considered how to leverage MHQP's directory. For example, to streamline data reporting efforts, providers may use the data MHQP collects to populate their state-mandated reports to the Commonwealth's database. However, obstacles to further collaboration included the fact that MHQP supports the development of its directory in part through revenue it receives through licensing its directory and restricts use and publication in its data use agreement, whereas the HPC and CHIA are required to report all elements of their provider registry publicly as provider registration by design is a sunshine law. Another issue is that provider participation in the MHQP directory is voluntary, whereas the HPC and CHIA registry is mandated by statute.

Quality Measurement: As noted previously, under the 2012 health care reform legislation, CHIA was mandated to convene a multi-stakeholder process to develop the Standard Quality Measure Set. Although MHQP has long collected and reported on physician quality measures, the statute gives CHIA the responsibility to collect and report on such metrics. The role of the RHIC in this work needs to be determined and appropriate funding mechanisms developed.

Convening and Engaging with Stakeholders: Massachusetts health care reform activities have long been characterized by deep partnerships among government agencies and market participants.

MHQP has established three stakeholder groups as part of their organizational governance—the Physician Council, the Health Plan Council, and the Consumer Health Council—and all three groups have equal representation on MHQP's board. Both CHIA and the HPC have advisory groups that include these stakeholder groups plus others, such as hospitals, provider trade associations, and employers, which are not coordinated through MHQP. The HPC is further overseen by an independent board comprising diverse health care experts, including academic researchers and representatives of consumers and organized labor, as well as those with experience in payer and provider settings (notably, the HPC and MHQP have one board member in common). As a result, many of the stakeholders participating with MHQP engage directly with the Commonwealth's policy-making processes.

Reform legislation over the last eight years has given statutory responsibilities to state agencies that overlap with some of the current roles of the RHIC. The state agencies and MHQP are working to develop a model for a collaborative relationship in the years ahead so that Massachusetts remains a leader in health care transparency and reform.

This duplication makes it challenging to define unique roles and responsibilities between the state agencies and the privately governed MHQP. Given the shared goals of the state and MHQP to achieve the Triple Aim for the residents of Massachusetts, conversations are ongoing to find appropriate mechanisms to strengthen state agency and RHIC collaboration and to balance the interests of many stakeholders who engage directly in the Commonwealth's policy-making processes.

Case Study #4

State of Oregon and Oregon Healthcare Quality Corporation

Oregon has been on the forefront of delivery system reform and has developed rich data resources to inform that work. A mature partnership relating to data collection and uses has supported the state and the RHIC in their respective governance, policy, and operational activities. As a result, there are multiple uses of their distinct and shared data resources for improvement including quality reporting, quality improvement, and payment reform. The Oregon case study illustrates the benefits of state-RHIC partnership but also the challenges relating to role definitions and collaboration that can arise.

The Team

- The **Oregon Health Authority (OHA)** is the state agency that administers most of Oregon's health care programs including public health, the Oregon Health Plan, Healthy Kids, and employee benefits, as well as public-private partnerships. The consolidation of purchasing responsibilities under OHA was designed to give the state greater policy authority and market power to tackle issues of cost, quality, and health care access.

- The **Office of Health Analytics** is part of OHA and manages the state's all-payer all-claims database, which was created by statute in 2009. The database includes claims from all commercial carriers and Medicaid. Researchers and others who are authorized can obtain limited data sets through an application process. The Office of Health Analytics also provides data to other government agencies for analysis.

- The **Oregon Health Care Quality Corporation (Q Corp)** is an independent, nonprofit statewide collaborative dedicated to improving the quality and affordability of health care in Oregon. Founded in 2000 by health plans in the state, Q Corp works with a variety of stakeholders—including consumers, providers, employers, policymakers, and health insurers—to develop community-based initiatives focused on quality and cost issues and to promote alignment of efforts to address those issues. An important function of Q Corp is to utilize data and analytics in support of these programs. For example, Q Corp has developed its own multi-payer claims database, which includes data from state programs.

Lessons Learned

These state agencies and Q Corp partner on a variety of initiatives, including those described below.

Governance: The state and Q Corp have distinct governance roles and functions, but they actively participate in each other's programs. The state has had a representative on Q Corp's board, and Q Corp staff has participated in the state's all-payer claims data technical advisory group.

The Oregon Healthcare Quality Reporting System (OHQRS): As a major purchaser of health care, the state contributes data for Medicaid beneficiaries and state employees to the OHQRS. It is a signature initiative of Q Corp and the state. Since 2008, Q Corp has been aggregating claims data from multiple payers to produce quality and utilization reports for consumers, providers, health plans, policymakers, and employers. OHQRS has claims data from 17 data suppliers, accounting for over 80% of the state's commercial insured population, 100% of the Medicaid population, and over 90% of the Medicare data. Q Corp, which generates more than 30 quality improvement and utilization measures from OHQRS, introduced a total cost of care measure at the clinic level in 2015, and intends to use it at the plan level.

The Patient-Centered Primary Care Institute: Q Corp manages the Patient-Centered Primary Care Institute, which accelerates primary care transformation in Oregon by making technical assistance and resources available to practices and other primary care stakeholders. The institute is a partnership between the state's medical home recognition program, technical assistance and content experts, and the many stakeholders who access resources. Through the institute, health care providers, clinic staff, technical experts, patients, quality improvement professionals, health plans, and others share valuable knowledge and resources. Resources are available for practices in all stages of primary care home transformation through an interactive website, in-person training, practice coaching, and a technical assistance learning network.

Independent Validation of Quality Metrics: Q Corp was commissioned by the state to validate metrics for the state's coordinated care organizations (CCOs), which serve as the foundation for the state's health care transformation programs. A CCO is a network of physical, behavioral, and dental care providers who work together in their local communities to serve Medicaid beneficiaries. CCOs are focused on prevention and helping people manage chronic conditions with the goal of keeping people healthy and reducing costly and otherwise avoidable emergency room visits. As a condition of its federal Medicaid waiver, the state is required to achieve certain health and cost savings outcomes. The CCOs, in turn, are accountable for achieving a comprehensive set of metrics to demonstrate their compliance and to assist the state in meeting its waiver commitments.

Quality Improvement Initiatives: As one of the state's largest purchasers of health care, OHA has required health plans that want to contract with the state to participate in Q Corp's quality improvement initiatives. For example, administrators of the Public Employees Benefit Board have a long-standing requirement that any insurer who wants state employee members must submit claims data to Q Corp. The Oregon Educators Benefit Board recently followed suit and adopted this requirement as well. In addition to serving as a tipping point for the participation of large carriers in Q Corp, this state purchasing lever has brought smaller insurers into the collaborative as they seek to enter the market.

Oregon's long history of health care reform activities has yielded tremendous opportunities for collaboration between the state and Q Corp. The state has established clear legal and policy authority to establish an all-payer claims database, and it is advancing robust accountability and improvement through the CCO program. As noted, Q Corp also established a robust claims database based initially on health plan data contributions and now including public program data from Medicaid and Medicare. As a result, both the state and Q Corp have invested in extensive databases and data analytics capabilities. They continue to define their unique roles and responsibilities and seek additional ways to share resources and collaborate. Each organization needs to achieve funding sustainability for its programs and will look for opportunities to create efficiencies that might spur further partnership activities.

Oregon is a leading example of health care transformation in the country, particularly in relation to quality improvement and performance measurement. Stakeholders at the state and local level historically have had strong commitments to, and made investments in, quality initiatives. On the flip side, data collection and measurement efforts in Oregon have proliferated, with many focusing on the same goals and outcomes. This has contributed to an overabundance of measures being adopted and reported, which can be burdensome for providers trying to respond to the numerous quality improvement efforts that are well-intended but may not be consistently aligned. The Oregon team recognizes that it can seek more effective alignment across activities and opportunities.

Conclusion

Health care transformation has gained notable momentum in the past five years due to increasing cost pressures on employers and individuals; new market dynamics, including demands for transparency and increased awareness of quality and safety shortcomings; and an aging population that will strain the existing health care system without significant structural change to enable better access and greater affordability.

Development of new models of care delivery and population health requires a combination of public policy leadership and the ability to build trust locally and establish capabilities through a multi-stakeholder governance model. Examples from successful partnerships between states and RHICs may provide lessons for other regions seeking to align their efforts.

- **States as catalysts, RHICs as conveners:** States often provide the policy direction and impetus to get all parties to the discussion table. State agencies play a central role in setting objectives through policy and funding priorities. However, if states are perceived as too dominant and central to governance, change becomes top-down, and other non-state stakeholders may be less inclined to support the state or remain engaged in the initiative. Policymakers may have a limited understanding of the barriers faced by stakeholders. Because they engage directly with physicians, payers, and employers within the community, RHICs bring local or regional insights to state policy and aid in implementation of policy at the local or regional level by providing technical assistance and support.

- **The “What” versus the “How”:** Because state government—particularly the governor’s office—plays a unique role in health and health care, the state can be an effective leader in setting the overall health care vision and goals for its residents. States can set expectations with other purchasers for such things as alignment of delivery system initiatives, measurements, and payment strategies. They can also reduce the potential for fragmentation and “initiative fatigue” for providers and help create economies of scale for payers. However, because health care is local and markets vary region by region, implementation of policy happens at the community and organizational levels. For this reason, strong multi-stakeholder engagement is needed to determine things like: how employers, providers, and consumers in the community engage in transformation; how they set their priorities; and what capabilities are needed to achieve delivery system and payment reform.

- **Clarity regarding roles:** States and RHICs are most effective when they create a structured and accountable process to review the state's vision and goals and the barriers to achieving those goals, and when they develop a strategy for how the regional collaborative can help the state achieve its goals and get past barriers. In other words, effective teams advance the ball toward the goal, even though they play different positions on the field. It is essential to clearly define roles and responsibilities needed to advance data aggregation, use, and reporting, and to identify which tasks the state will lead and which tasks the collaborative will champion. Each entity has multiple levers and resources to bring to bear and can be most effective when working in alignment.

- **Coming together for population health:** To improve population health, information must include the entire population. Data segmented by payer or provider does not provide a full view of the population or the ability to manage population care and cost. Leadership must span single organizations and entities to align across communities. States not only contribute to policy direction, but also are major purchasers in each state and manage care for both state employees and Medicaid populations. RHICs represent purchasers and consumers from across the community. By combining efforts, state and RHIC partnerships can represent a broad population perspective on health and health care improvement.

- **Governance and stakeholder engagement:** The collaborative governance model for an APCD or shared database can foster authentic engagement of all stakeholders. Having a governance structure perceived either as dominated or unduly influenced by either the government or by the private health care industry or a single stakeholder group can politicize data uses. Bringing everyone along voluntarily—even dissenters—can be an exercise in patience and planning. It can be difficult for state leaders who operate on annual budgets and election cycles. Sustained engagement of all stakeholders is facilitated through a structured governance model and by building trust and longevity in personal relationships.

- **Cultural differences between the public and private sector.** Lastly, cultural differences between states and regional collaboratives must be acknowledged and overcome. State agencies feel strongly that they are guardians of the public good and may perceive conflicting interests from industry stakeholders engaged in regional collaboratives. Likewise, multi-stakeholder collaboratives might feel wary about state agencies wearing different hats (purchasers, provider, regulator, etc.) at different times, which changes the authenticity and dynamics of collaboration.

In conclusion, states and RHICs can be united around common goals—specifically, to achieve the Triple Aim and reduce the overall costs of health care. Achieving these goals requires a structured governance and partnership model. These partnerships take time and effort to start and sustain. While partnerships may take different forms across the country, this structured approach has been used to establish common policies for the collection and use of data that drives improvement across populations and regions.

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness. www.milbank.org.

About the Network for Regional HealthCare Improvement (NRHI)

The Network for Regional Healthcare Improvement (NRHI) is a national organization representing 35 member Regional Health Improvement Collaboratives (RHICs). These multi-stakeholder organizations are working in their regions and collaborating across regions to transform the healthcare delivery system and achieve the Triple Aim: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per-capita cost of healthcare. The RHICs are accomplishing this transformation by working directly with physicians and other healthcare providers, provider organizations, commercial and government payers, employers, consumers, and other healthcare-related organizations. NRHI's mission is to improve health and healthcare in communities across the U.S. through an active and engaged network of RHICs. Both NRHI and its members are non-profit, non-governmental organizations.