State Health Quality and Cost Councils

A WHITE PAPER

Prepared for

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

by

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August 2008

Introduction

Colorado, like many other states, is embarking upon a major public-private initiative to improve health care quality, access and cost-effectiveness. Colorado has a higher median household income than the national average, and is often referred to as a healthy state given its relatively low obesity rates and active lifestyle. For example, the 2007 Commonwealth Fund State Scorecard on Health System Performance ranks Colorado second in the country for Healthy Lives. However, Colorado rates only average or below average on many indicators that measure overall health, especially those measuring the health of infants, children and adolescents. The Commonwealth Fund ranks Colorado 43rd on Health Care Equity, 30th on Quality and 35th on Access. The Colorado Health Foundation's 2007 Colorado Health Report Card scores Colorado a C- on prenatal/infant health and child health. Moreover, Colorado's public insurance programs have relatively low eligibility thresholds and, therefore, cover a smaller percent of the population than in many states. Seventeen percent of Colorado's population is uninsured, and the insurance market is dominated by small group insurance. Health care expenditures in Colorado, as in other states, continue to rise and to make up an increasing portion of the state budget, while the number of uninsured Coloradans continues to grow. In 2006 the Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform (also know as the 208 Commission) to identify strategies to expand health care coverage and reduce health care costs for Coloradans.

The Blue Ribbon Commission for Health Care Reform identified a need for an authority to address quality, cost and incentive issues and inform health care reform initiatives. Governor Bill Ritter has identified several building blocks for health care reform that build on the Commission's recommendations, including the creation of the Center for Improving Value in Health Care (CIVHC). Governor Ritter's February 2008 executive order creating CIVHC states that "in Colorado, there is an evident need to develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care," and recommends that an inter-agency, multi-disciplinary center fill that role. The executive order created a steering committee charged with defining the structure and scope of CIVHC. This white paper provides an analysis of existing state health quality and cost councils to inform the steering committee's recommendations regarding the Center for Improving Value in Health Care (CIVHC).

Colorado is well-poised to establish a quality and cost council. The activities of the governor and the Blue Ribbon Commission have heightened public and private awareness of these issues, spurring a discourse about health care value and a search for solutions among stakeholders throughout the state. In addition, a number of respected organizations in Colorado are already actively engaged in activities typical of quality and cost councils, including but not limited to:

- Evidence-based practice and quality improvement (QI) efforts at numerous public and private provider practices, HMOs, and insurers, often linked to national QI efforts
- Evidence-based QI efforts across provider groups facilitated by the Colorado Business Group on Health, the Colorado Foundation for Medical Care, and others
- The work on evidence-based guidelines and the Medical Home model led by the Colorado Clinical Guidelines Collaborative
- Public reporting on quality by the Colorado Hospital Association
- Heightened reporting and analysis of health care data with the establishment of the Colorado Health Institute in 2002
- Efforts to create data exchange with the development of the Colorado Regional Health Information Organization

Similar to Colorado, most states have within them one or more organizations that promote health care quality improvement and cost containment. There is an increasing recognition, however, that the system transformation needed to significantly impact quality and cost at a community and statewide level requires a vision and strategy that unites payers, providers, and consumers across the health care system. Rather than duplicate existing efforts, Colorado should draw upon the strengths of the organizations listed above. By adopting a new structure and leadership to provide direction and coordination, Colorado will be able integrate and expand existing health care quality and cost initiatives. With this new entity, Colorado will create a unifying vision and approach to improving health care in the state that could not be accomplished with the existing state structure.

CIVHC may have broader responsibilities than quality and cost councils in some other states. Nevertheless, the CIVHC steering committee can benefit from the experience of quality and cost councils in other states. The findings in this white paper are the results of a review of quality and cost council annual reports and web sites, and interviews with key informants at various councils. This white paper provides recommendations for how these models–specifically, aspects of the councils in Massachusetts, Maine, Vermont, Pennsylvania, Washington and Oregon – may be adapted for Colorado.

Mission and Framework

As a first key decision, Colorado must determine CIVHC's mission and goals. Generally speaking, statewide quality and cost councils have been developed to address two related issues: quality improvement and cost containment. As expected, the missions of quality and cost councils speak to these broad goals. However, each council's mission also reflects the unique environment of the state, the level of engagement of the State in health care reform efforts, and the state's health care priorities. In addition to quality and cost, many council missions assert other goals, including:

- Reducing health disparities
- Supporting consumer health care choices

Quality and Cost Council Missions, with Unique Elements Highlighted

State	Mission
MA	To develop and coordinate the implementation of health care quality improvement goals intended to contain growth in health care costs and improve quality of care, including **reductions in racial & ethnic health disparities**
ME	To advocate for high quality healthcare and **help each Maine citizen** make informed health choices
OR	To lower costs, improve quality, and assure every Oregonian **affordable health insurance**
PA	To address problem of escalating health costs, ensure quality of health care, and **increase access for all citizens regardless of ability to pay**
VT	Vermont will have a statewide system of care that **improves the lives of individuals living with and at risk for chronic conditions** (Vision Statement)
WA	To provide increased access to health care quality information for providers, employers/ purchasers, plans and consumers (Goal)

- Increasing health care access

CIVHC is intended to be one element of a larger state health care reform effort and is not charged with improving access to care, which is being addressed through other elements of the Governor's Building Blocks and specific task forces. Colorado may want to draw upon the missions and frameworks of other states' councils that have been developed in a similar context. Maine, Massachusetts, Vermont, and Washington in particular, were formed as part of a broader health care reform effort in their respective states, and thus may be particularly relevant to Colorado.

Massachusetts's health care reform was focused on increasing health care coverage, and thus access. With the basic structure for health care reform in place, the Health Care Quality and Cost Council is charged with coordinating the implementation of quality improvement goals that both improve quality of care and contain growth in costs.

In **Maine**, the Maine Quality Forum was created within the Dirigo Health Agency, which is charged with overall reform.

In **Vermont**, health care reform was designed around a conceptual framework based on the MacColl Institute's Chronic Care Model.[1] The Vermont Blueprint for Health was charged with developing and implementing a strategic plan for statewide chronic care and prevention within the context of broader reform. The Chronic Care Model emphasizes important elements of the health care system: the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. The model asserts that evidence-based transformations of each element will foster productive interactions between informed patients and providers with resources and expertise.

The Healthy **Washington** Initiative was created by the Governor, and based on recommendations of the Blue Ribbon Commission on Health Care Costs and Access. The Healthy Washington Initiative includes goals related to health care coverage, quality of care and cost containment, including the establishment of the Washington State Quality Forum. The Forum is unique in part for collaborating with the Puget Sound Health Alliance, an independent non-profit organization that, like the Forum, is dedicated to developing evidence-based clinical guidelines, producing public reports on health care quality, and promoting value-based purchasing.

Colorado may want to consider aspects of quality and cost councils' mission statements, listed to the right.

Role and Functions

The major functions of quality and cost councils depend on the specific mission of each council and the degree to which other agencies or organizations in the state are able to contribute to achieving goals.

1 Wagner, Edward T., Brian T. Austin, and Michael von Korff. Organizing Care for Patients with Chronic Illness. The Millbank Quarterly. 1996. 74 (4): 511-44.

Existing councils assume a broad range of functions, including administration, planning, implementation, coordination, leadership, data collection, data reporting, and aligning incentives. It seems logical for CIVHC to avoid creating a large new structure, but rather to act as an entity that coordinates and leverages existing resources. If CIVHC takes on this role, it will avoid supplanting or duplicating work already being conducted in the state. Nevertheless, CIVHC may also consider centralizing data functions, quality improvement implementation, and/or working to align incentives across existing initiatives. The Blue Ribbon Commission on Health Care Reform has identified specific roles for CIVHC. The table on page 6 illustrates the functions identified by the Blue Ribbon Commission and other state councils that are charged with the same or similar roles.

Blue Ribbon Commission Recommendations for CIVHC	Selected Councils Charged with Role		
Become a Rule-Making Authority By:	MA	VT	WA
Reducing administrative costs through administrative streamlining and review of regulatory requirements	X	X	
Ensuring that the information on insurers, provider price, and provider quality is available to all Coloradians	X		
Designing the minimum benefit package and consumer advocacy program			
Become an Advisory Authority By:			
Increasing the use of prevention and chronic care management	X	X	X
Paying providers based on quality	X	X	X
Supporting the provision of evidence-based medicine		X	X
Improving end-of-life care	X		
Providing a medical home for all Coloradians		X	
Supporting the adoption of health information technology		X	X
Overseeing development of a statewide system aggregating data from all payer plans, public and private	X	X	X
Assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety-net providers	X		

Quality and cost councils can also play an important role in transforming state Medicaid programs, as well as in system change at the state level. For example:

Vermont hired an outside vendor to implement a chronic disease management program within Medicaid. At the same time, Vermont is implementing a broader statewide program that applies to all the providers in the state delivering care to people with chronic diseases.

In **Massachusetts**, the legislature recently appropriated $20 million for a medical home program targeted specifically to the state's Medicaid program. Thus, as in these states, there may be opportunities in Colorado to improve care for recipients of public and private health care benefits.

Authority and Relationship to State Government

Although Governor Ritter has already authorized the establishment of CIVHC with an executive order, Colorado may want to consider seeking approval of the legislature, as well, by ensuring that CIVHC will report annually to the legislature and including key legislative leadership in its membership. Doing so will increase CIVHC's sustainability and increase its profile with both stakeholders and the general public. The Vermont Blueprint for Health Executive Committee and the Maine Quality Forum Advisory Council, which were initially established by their respective governors, were ultimately also approved by the legislature.

The location of CIVHC in state government will be informed by the intended functions of the council. If the CIVHC steering committee determines that CIVHC should exert significant influence on health care reform in the state, then it seems that CIVHC would be most appropriately located high in the government structure. Such a location would afford CIVHC visible support from the governor, facilitate coordination with other government agencies and departments, and help leverage commitments from public and private partners.

- In an effort to increase coordination across state agencies, **Vermont's** Blueprint and council were recently moved from the health department to the Agency for Administration, a higher position in state government. Although all quality and cost councils being considered as models for Colorado are located within state government, their specific locations vary.

- **Massachusetts's** council is located within an existing state agency (the Executive Office of Health and Human Services), **Vermont** and **Washington's** are within the office implementing health care reform, whereas **Pennsylvania's** council has been developed as an independent state agency

- As noted above, while most councils report to the state legislature, some councils are also required to report to the governor, the state agency within which they are housed and, in the case of **Maine**, consumers.

Determining CIVHC's location in state government may, in turn, help determine CIVHC's leadership. For example:

- Because Massachusetts's council is located in the Executive Office of Health and Human Services, the council is chaired (ex-officio) by the Secretary of Health and Human Services.
- For similar reasons, Vermont's council has three chairpersons: Executive Director of the Vermont Blueprint for Health, Commissioner of the Vermont Department of Health, and Executive Director of the Vermont Association of Hospitals & Health Systems.

Regardless of where the council is housed, it is important that the council chair be an influential leader.

The council's relationship to the legislature is an important consideration in establishing CIVHC. State legislatures can potentially play important roles in broadening council support and participation, appropriating funds, and developing policy. In most states, the legislature has played such a role in establishing and overseeing the activities of quality and cost councils. To solicit participation from the legislature, it may be helpful to seek their input in council structure, leadership, and operations. For example, most existing councils have enabling legislation that prescribes the councils' composition (specific positions and/or types of representation). It may also be beneficial for the steering committee to seek legislative representation in the CIVHC membership.

Membership and Structure

As expected, the composition of each council reflects the mission and major functions of the council. CIVHC membership should include those entities already engaged in supporting the core activities of quality councils, including specifically quality improvement organizations and data management organizations. Because the existing organizations involved in these activities represent both public and private stakeholders, CIVHC should consider including membership, as many other quality and cost councils do, from the following groups:

- State agency heads/officials
- Health policy experts
- Non-government insurance purchasers
- Health care providers
- Business
- Consumers

Some councils have member representation from other groups, as well, which reflect the individual states' priorities and unique stakeholders. For example:

The **Pennsylvania** and **Minnesota** councils are required to include representation from organized labor, while **Alaska's** council includes representatives of faith-based and philanthropic agencies.

The **Washington State Quality Forum** is required to work closely with the **Puget Sound Health Alliance**, which has been very successful in getting public and private purchasers to work together closely on quality improvement initiatives.

The quality and cost councils reviewed have between thirteen and twenty-two members. Depending on the desired scope of the council, Colorado may solicit additional input through committees and/or an advisory group.

- Pennsylvania and Maine's councils both have committees located within the councils that focus on the following issues: data systems, education, benefits review, technology assessment, performance indicators, and community engagement.
- In states where the councils are independent state agencies (as in Pennsylvania or Maine) or within an agency dedicated to health care reform (as in Massachusetts and Vermont), the councils have an advisory committee that provides input to a dedicated staff.
- Most councils engage providers in the design specific goals and measures through council committees or subcommittees.

Whatever the scope of the council, the CIVHC steering committee should ensure that CIVHC's structure and membership will foster its sustainability in future administrations.

Common Sources of Quality and Cost Council Funding in Other States

>> **State appropriations** *including funding mechanisms for overall health care reform, such as tobacco taxes or health care financing*

>> **State agency budgets**

>> **Federal funding**

>> **Revenue from the sale of data and reports**

>> **Foundation dollars for start-up activities and in support of specific initiatives**

>> In Vermont, the Blueprint Pilot communities are securing the **commitment of private payors** over the course of the pilot to redirect existing dollars to support the chronic care model (a portion of the work of the council).

Staffing and Funding

It will be important for Colorado to have a dedicated staff that can represent the council's vision and goals across agencies and with public and private partners. As with many previously mentioned characteristics of CIVHC, the number of staff will in part depend on the number and type of functions that the council will centralize or coordinate. Among existing quality and cost councils, staffing ranges from a few staff (in Massachusetts, Maine and Washington) to over sixty staff (in Pennsylvania). It appears that councils have historically refined their staffing numbers and expertise as they have gained experience and better defined their roles. Most councils also reserve the authority to engage outside expertise if necessary to accomplish set goals.

The number of functions and staff will also help determine the appropriate budget for CIVHC. For those existing councils that are within state agencies, some funding is discretely identified to support the functions of the council, along with dedicated staffing, with the understanding that the agency as a whole supports the work of the council. Funding for the councils in Maine and Massachusetts was $1 million in 2007 and $5.7

million for the entire Vermont Blueprint for Health in 2009, which includes funds for the council and administrative functions. In Washington, the council received $1.3 Million for its first biennium. See box to the left for a list of common sources of quality and cost council funding in other states.

Summary and Recommendations

The creation of CIVHC is integral to addressing the state's health care problems. CIVHC has the opportunity to integrate and expand existing quality improvement and cost containment efforts in the state by acting, at the very least, as a coordinating and planning entity. Based on goals stated by Governor Ritter and the Blue Ribbon Commission for Health Care Reform, it seems that there is consensus in Colorado to take a broad approach and make CIVHC a key player in planning and promoting next steps in state health system reform.

As a next step, the CIVHC Steering Committee must verify the intended direction of the council and translate these broad recommendations into a specific plan. Creating a plan that addresses the set of core characteristics described above – mission, framework, functions, authority, location in government, membership, structure, staffing, and funding – will foster consensus-building and facilitate efficient development of the council.

The following recommendations are based on Colorado's priorities for CIVHC and the experience of quality and cost councils in other states:

Conceptual Framework/Vision

Because CIVHC is charged with leveraging existing efforts and providing statewide leadership on system reform, it should adopt a conceptual model, such as the chronic care management model It Takes a Region, the Patient-Centered Medical Home model, or a health care reform model to guide its efforts. Such a framework will allow CIVHC to focus its activities, ensure that CIVHC supports and is supported by broader reform efforts in the state, and provide an effective evidence-based approach to policymaking.

Mission

CIVHC's Mission should include at a minimum:

- Providing statewide leadership and vision on health care quality and value efforts
- Bringing together the diverse efforts and resources that already exist within the state
- Strengthening public and private partnerships related to quality and value, including health system reform efforts.

Roles and Functions

CIVHC's Roles and Functions should include:

- Identifying and supporting strategies that work toward achievement of CIVHC's mission
- Providing leadership and vision around health system reform, informed by best practices and current knowledge
- Effectively engage providers, payers and consumers in its efforts
- Actively participate in, but not lead, policy discussions related to health care reform/ expansion, etc.
- Support implementation of health system reform strategies, as appropriate

In its first year of operation CIVHC should identify its primary goals and strategies for achieving its mission, and develop a road map for its initial activities.

As discussed above, there are a number of organizations and initiatives in Colorado that are currently conducting aspects of the roles and functions that many quality and cost councils undertake, including collection and public reporting of data, consumer engagement, and support for practice or system improvement.

CIVHC should support and enhance the capacity of existing organizations and engage them in its activities rather than duplicating capacity. In order to do so, CIVHC should conduct a thorough analysis of existing capacity, identify areas that need to be enhanced, and develop a plan for increasing capacity. CIVHC's road map of initial activities should specify how it will utilize and build upon the current capacity.

Authority and Relationship to State Government

CIVHC should be located at a level in state government that allows it to provide leadership and leverage resources across state agencies, and to engage in high-level public-private partnerships. The governor's executive order established CIVHC initially under the leadership of the Director of the Department of Health Care Policy and Finance.

Given the commitment of the governor and the Department to CIVHC and their ability to contribute to CIVHC's development and mission, we recommend that CIVHC continue operations under the Department. Once CIVHC establishes and refines its priorities and activities, it should re-examine whether a different placement in relationship to state government will allow it to better meet its goals.

Location of CIVHC within state government could potentially make it vulnerable to shifting priorities in future administrations and to state budget pressures. CIVHC should develop a sustainability plan within its first several years of existence that addresses these issues.

Membership and Structure

Because CIVHC's primary role is to engage state leaders in health system reform, its advisory body should consist of individuals who are passionate about health system reform and who can mobilize critical sectors. They should include business leaders, health care leaders, legislators, state officials, and consumers or consumer representatives.

CIVHC membership structure should include committees or working groups that engage the entities already supporting the core activities of quality councils, including specifically quality improvement organizations and data management organizations. Its structure should explicitly facilitate the participation of non-governmental organizations already working toward CIVHC's goals in identifying and implementing CIVHC's work plan.

Staffing and Funding

CIVHC should be lead by dedicated staff who can provide strategic leadership and garner support and commitments from key stakeholders. CIVHC should have sufficient staffing to support any committees or workgroups recommended by the steering committee. To the extent that CIVHC takes on the direct support of system reform, staff with specific expertise in those areas should be hired. Based on the experience of quality and cost councils in other states, a minimum of 1.5 to3 FTE should be hired to support CIVHC's initial activities.

CIVHC should be funded, initially, with dedicated state dollars, but should strive to diversify its funding base.

Conclusion

CIVHC represents an important long-term investment by the state of Colorado in improving its health care system. Although all states currently face budget pressures, it is critical to maintain a commitment to reforms that will produce a lasting impact on the quality and cost of health care in Colorado. CIVHC represents this commitment to health system improvement and is essential to realizing Governor Ritter's vision of reform.

Maine Quality Forum Council	
STRUCTURE	
Location within state government	Independent division of Dirigo Health
Date of legislation	Quality forum created in 2003 as part of Dirigo Health, further defined on 10/1/07
Reports to	Dirigo Health Board (Dirigo Health Board is the governing body for the forum)
Legislative Authority	Created by governor and legislature (Executive Order 01.01.2007.24)
Members	17 members
Member stakeholder groups	Providers, health insurance, business, public policy, research
Member selection process	Appointed by Governor, approved by HHS Standing Committee
Committees	Technology assessment, performance indicator, community engagement
Advisory group	Maine Quality Forum Advisory Committee Provider Group (PG) consisting of health care providers nominated by peers and selected by MQF-AC
Decision-making process	
Leadership	Chairperson
Staffing (including # FTEs)	Executive director, administrative assistant, comprehensive health planner, epidemiologist
Budget	$1 million (excluding personnel)
MISSION & FUNCTIONS	
Mission	To advocate for high quality healthcare and help each Maine citizen make informed healthcare choices
Major functions	Collect research, promote best practices, collect and publish comparative quality data, promote electronic technology, promote healthy lifestyles, report to consumers and legislature
Policy-making capabilities	None. Must report to Dirigo Health Agency director
Data collection	Hospital services quality, payclaims database (RAPHIC), collect core and expanded set of indicators
Reporting	Provides information/resources for consumers on web site regarding provider quality and cost; released annual report (2004) re: direct care nurse staffing in hospitals
MAJOR INITIATIVES	
Accomplishments	Annual report on direct care nurse staffing in hospitals (2004); Maine HealthInfoNet; quality analysis charts of Maine hospitals available on website; information for consumers available on website
Measurable results	

Maryland Health Care Commission	
STRUCTURE	
Location within state government	Independent regulatory agency
Date of legislation	1999
Reports to	Governor and general assembly
Legislative Authority	Created by the Maryland General Assembly; Annotated Code of Maryland, Health General Article § 19-101
Members	15 members
Member stakeholder groups	Research, health policy, education, retirement community, nursing, health insurers, public health agencies, providers
Member selection process	Appointed by governor, with advice and consent of senate
Committees	Health resources, performance and benefits, data systems and analysis
Subcommittees	Acute and Ambulatory Care Services Division, Specialized Health Care Services Division, Long Term Care and Mental Health Services Division, Certificate of Need program staff; Benefits Analysis, Special Projects, HMO Quality & Performance Division, Facility Quality & Performance Division; Database and Application Development Division, Cost and Quality Analysis Division, Electronic Data Interchange (EDI) Programs and Payer Compliance Division, Network Operations and Administration Systems
Advisory group	
Decision-making process	
Leadership	Chairperson and Vice Chairperson
Staffing (including # FTEs)	Executive Director, Deputy Director of Health Resources, Deputy Director of Performance and Benefits, Deputy Director of Data Systems and Analysis, Associate Deputy Director, three Assistant Attorneys General; 65 FTEs (for FY 2005)
Budget	$10,124,187 (for FY 2005; at the close of FY 2005, the Commission's surplus was $3,498,540)
MISSION & FUNCTIONS	
Mission	To plan for health system needs, promote informed decision-making, increase accountability, improve access by providing information on availability, cost, and quality of services to policy makers, purchasers, providers and the public
Major functions	Develop and administer a plan for health insurance for small businesses and the self-employed that includes affordable, standardized, comprehensive benefits; assess the financial, medical, and social impact of proposed mandated health insurance services; administer a system of evaluating the quality and performance of commercial HMOs, nursing homes, hospitals, and ambulatory surgery facilities and publish findings; create a data base of expenditures and utilization of health care services provided in settings other than hospitals; regulate the electronic transmission of health care claims
Policy-making capabilities	
Data collection	Statewide Medical Care Data Base of services rendered by health care practitioners
Reporting	Report quality measures, including hospital infections, patient and family satisfaction
MAJOR INITIATIVES	
Accomplishments	Annual report on health care expenditures in Maryland; analysis of the problem of the uninsured in Maryland; summary of insurance coverage in the state; special studies of importance to policymakers, including prescription drug spending, uncompensated care, and primary care services
Measurable results	

Commonwealth of Massachusetts Health Care Quality and Cost Council	
STRUCTURE	
Location within state government	Massachusetts Executive Office of Health and Human Services
Date of legislation	2006
Reports to	Legislature
Legislative Authority	Established by Chapter 58 of the Acts of 2006
Members	13 members (including designees by members serving ex-officio)
Member stakeholder groups	Insurance, administration, health care quality improvement organizations, health policy experts
Member selection process	7 members appointed by Governor: 1 from a CMS QI organization, 1 from the Institute for Health-care Improvement, 1 from the MA Chapter of the Nat'l Assn. of Insurance and Financial Advisors, 1 from the MA Assn. of Health Underwriters, 1 from the MA Medicaid Policy Institute, 1 health policy expert, 1 non-governmental purchaser of health insurance. Other members: Secretary of HHS, auditor of the Commonwealth, inspector general, attorney general, commissioner of insurance, executive director of the group insurance commission.
Committees	May create standing and temporary committees as necessary to functioning of Council
Advisory group	24-member advisory committee that includes representation from consumers, business, labor, providers, health plans
Decision-making process	
Leadership	Secretary of Health and Human Services (ex officio) serves as Chairperson; Vice Chairperson elected by Council members annually for a one-year term
Staffing (including # FTEs)	Executive Director directs administrative affairs and operations; may employ staff or consultants; may contract with an independent health care organization to provide technical assistance
Budget	$1 million (2008); $1.9 (projected for 2009)
MISSION & FUNCTIONS	
Mission	To develop and coordinate the implementation of health care quality improvement goals intended to contain growth in health care costs and improve quality of care, including reductions in racial and ethnic health disparities
Major functions	Establish goals for improving health care quality, containing costs, reducing racial/ethnic disparities; progress toward achieving those goals; disseminate, through website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public
Policy-making capabilities	Council may recommend legislation or regulatory changes to the legislature
Data collection	Adopted Uniform Reporting System for Health Care Claims Data Sets (2007): requires all health insurance carriers to submit health care claims information; other data collection on health care quality and cost expected to be publicly available on website in June 2008
Reporting	Releases annual report re: strategies to improve health care while containing costs; must file a report, not less than annually, with the joint committee on health care financing and the clerks of the house and senate on its progress in achieving goals
MAJOR INITIATIVES	
Accomplishments	Consumer website with quality and cost information; adopted six health care QI goals intended to contain costs while improving quality and reducing health disparities, developed strategies for controlling costs. Reporting on variations in rates paid by various entities. Developed strategies for improving quality and management of health care for MA citizens
Measurable results	

Oregon Health Fund Board	
STRUCTURE	
Location within state government	Department of Human Services (DHS)
Date of legislation	27-June-2005
Reports to	Governor and legislature
Legislative Authority	Senate Bill 329—Healthy Oregon Act
Members	7 members
Member stakeholder groups	Consumer advocacy, management, finance, labor, health care, state government
Member selection process	Appointed by governor; members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.
Committees	Federal Laws, Financing, Delivery Reform, Benefits, Health Equities, and Eligibility & Enrollment PLUS Quality Institute Workgroup
Advisory group	None
Decision-making process	A majority of the members of the board constitutes a quorum for the transaction of business. Official action by the board requires the approval of the majority of the members of the board.
Leadership	Chairperson and Vice Chairperson elected by board
Staffing (including # FTEs)	
Budget	$1,215,350 to the DHS to carry out the Healthy Oregon Act
MISSION & FUNCTIONS	
Mission	To lower costs, improve quality and assure every Oregonian affordable health insurance
Major functions	Citizen board responsible for making decisions about financing, eligibility, benefits, delivery, and overall administration of the Oregon Health Fund program
Policy-making capabilities	
Data collection	None
Reporting	Final draft of plan due to Governor by October 1, 2008. Required to report to legislature with comprehensive plan by early 2009.
MAJOR INITIATIVES	
Accomplishments	
Measurable results	

Pennsylvania Health Care Cost Containment Council (PHC4)	
STRUCTURE	
Location within state government	Independent state agency
Date of legislation	17-July-2003 (reenacting and amending the act of 8-July-1986 (P.L.408, No.89))
Reports to	Legislature
Legislative Authority	Formed under Pennsylvania statute (Act 89, as amended by Act 14)
Members	22 members: executive committee members (6), additional committee members (16)
Member stakeholder groups	Labor, business, physicians, nurses, administration, health plans, HMOs, hospitals
Member selection process	Appointed: Secretary of Health, Secretary of Public Welfare, Insurance Commissioner, 6 business reps, 6 labor reps, 1 consumer rep, 2 hospital reps, 2 physician reps, 1 QI expert, 1 nurse rep, 1 BCBS-PA rep, 1 insurance rep, 1 HMO rep
Committees	Data systems, education, mandated benefits review
Advisory group	Technical Advisory Group responds to issues related to research methodology, statistical expertise, and risk-adjustment methods; composed of physicians, biostatisticians, and health services researchers
Decision-making process	13 members, at least 6 of whom must be made up of representatives of business and labor, shall constitute a quorum for the transaction of any business, and the act by the majority of the members present at any meeting in which there is a quorum shall be deemed to be the act of the Council.
Leadership	Executive Committee
Staffing (including # FTEs)	Approximately 60 FTE. Health care professionals support the council's mandate through the collection, analysis, and reporting of cost and quality data about health care services in PA
Budget	Funded through the PA state budget; also receives revenue through the sale of its data to healthcare stakeholders around the state, the nation, and the world.
MISSION & FUNCTIONS	
Mission	To address problem of escalating health costs, ensure quality of health care, and increase access for all citizens regardless of ability to pay
Major functions	Collect, analyze, make available data re: cost and quality of health care; study access for uninsured; make recommendations re: mandated health insurance benefits
Policy-making capabilities	
Data collection	Collects over 3.8 million inpatient hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers in PA (includes hospital charge and treatment information, and other financial data); data collected quarterly and verified by PHC4 staff; also collects data from managed care plans on a voluntary basis
Reporting	Free public reports (hundreds since council's creation); reports found on council's web site and in most public libraries throughout the state; also produced hundreds of customized reports and data sets through its Special Requests division for hospitals, policy-makers, researchers, physicians, insurers, and other group purchasers; report topics include: cardiac care, county profiles, diabetes, hip/knee replacements, HMOs, hospital-acquired infections, hospital finances, hospital performance
MAJOR INITIATIVES	
Accomplishments	
Measurable results	

Vermont Blueprint for Health Executive Committee	
STRUCTURE	
Location within state government	Vermont Agency of Administration
Date of legislation	2006
Reports to	Legislature
Legislative Authority	Launched by Governor Douglas, endorsed by Vermont General Assembly (Act 191)
Members	19 members (including leadership)
Member stakeholder groups	Vermont Blueprint for Health, Vermont Department of Health, hospitals, health care reform, BCBS, medical association, health care administration, insurance, AARP, Office of Vermont Health Access
Member selection process	Sec. 5 18 702 (c)(1) The secretary shall establish an executive committee to advise the director of the blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall consist of no fewer than 10 individuals, including the commissioner of health, a representative from the department of banking, insurance, securities, and health care administration; the office of Vermont health access; the Vermont medical society; a statewide quality assurance organization; the Vermont association of hospitals and health systems; two representatives of private health insurers; consumer; a representative of the complementary and alternative medicine profession; a primary care professional serving low income or uninsured Vermonters; and a representative of the state employees' health plan, who shall be designated by the director of human resources and who may be an employee of the third party administrator contracting to provide services to the state employees' health plan.
Committees	N/A
Advisory group	Community Advisory Group with representation from the Department of Health, Department of Transportation, University of Vermont Department of Nutrition and Food Sciences, Office of VT Health Access, VT Leauge of Cities and Towns, Dartmouth Medical School (Master of Public Health Program), Central VT Medical Center, hospitals; Health Systems Advisory Group with representation from American Academy of Pediatrics, CIGNA, VT Assembly of Home Health Agencies, Office of VT Health Access, Vermont Managed Care, Dept of Aging and Independent Living, IBM, Northease Health Care Quality Foundation, Great Western Healthcare; Provider Practice Advisory Group with representation from CIGNA, Fletcher Allen Health Care, BCBS, Central VT Medical Center, VT Department of Health, Office of VT Healthcare Access; Self-Management Advisory Group with representation from University of Vermont Family Medicine Department, Chronic Conditions InfoNet, Northwestern Medical Center, VT Dept of Health (including Dept of Adult Mental Health, Tobacco Chief, Arthritis Program), Fletcher Allen Health Center
Decision-making process	Executive committee makes recommendations to the Director of Blueprint, who reports to the legislature
Leadership	3 Chairpersons (Executive Director of VT Blueprint for Health, Commissioner of VT Department of Health, Executive Director of VT Association of Hospitals & Health Systems)
Staffing (including # FTEs)	8 staff (public health administrators and specialists, information system project manager & developers, communication specialists, statistician/analyst, business manager, administrative support)
Budget	$5.2 Million proposed for 2009. Funding from Global Commitment (1115a waiver, Catamount Fund and Federal Funds)

Vermont Blueprint for Health Executive Committee, continued	
MISSION & FUNCTIONS	
Mission	Vermont will have a statewide system of care that improves the lives of individuals with and at risk for chronic conditions (Vision Statement)
Major functions	Utilize the Chronic Care Model as the framework for system change; utilize a public-private partnership to facilitate and assure sustainability of the new system of care; and facilitate alignment of Blueprint priorities and projects with other statewide health care reform initiatives
Policy-making capabilities	Not explicit
Data collection	Related to implementation of chronic care model, goals, and outcomes
Reporting	Strategic Plan Preliminary Report: implementation structure recommendation and timeline, legislative updates, legislative reports; report to legislature annually.
MAJOR INITIATIVES	
Accomplishments	Establishment of pilots for advanced medical homes
Measurable results	

Washington State Quality Reform	
STRUCTURE	
Location within state government	Washington Department of Health, Health Care Authority
Date of legislation	22-July-2007
Reports to	Legislature
Legislative Authority	Part of the "Healthy Washington Initiative" created by governor and based on recommendations by the Blue Ribbon Commission on health Care Costs & Access, Senate Bill 5930, Section 9
Members	Appointed by administrator
Member stakeholder groups	Federal, state, and local government; labor; health care; insurance providers
Member selection process	Appointed by administrator
Committees	As needed
Advisory group	As needed
Decision-making process	
Leadership	
Staffing (including # FTEs)	4 FTEs (Program Director, Medical Consultant Project Specialist, Administrative Support)
Budget	$1.3 million for 2007-2009 biennium
MISSION & FUNCTIONS	
Mission	Provide increased access to health care quality information for providers, employers/ purchasers, plans, and consumers
Major functions	In collaboration with the Puget Sound health alliance and other local organizations, the forum shall: (1) collect and disseminate research regarding health care quality, evidence-based medicine, and patient safety to promote best practices in collaboration with the technology assessment program and the prescription drug program; (2) coordinate the collection of health care quality data among state health care purchasing agencies; (3) adopt a set of measures to evaluate and compare health care cost and quality and provider performance; (4) identify and disseminate information regarding variations in clinical practice patterns across the state; and (5) produce an annual quality report detailing clinical practice patterns for purchasers, providers, insurers and policy makers. The agencies shall report to the legislature by September 1, 2007 and have a website by March 28, 2008.
Policy-making capabilities	
Data collection	Collected with the help of the Department of Health
Reporting	Annual quality report to the legislature
MAJOR INITIATIVES	
Accomplishments	
Measurable results	

Puget Sound Health Alliance (King County, Washington)	
STRUCTURE	
Location within state government	Independent non-profit organization
Date of legislation	December 2004
Reports to	King County Executive Ron Sims
Legislative Authority	Founded by Ron Sims upon recommendation by the King County Health Advisory Task Force
Members	21 Board members
Member stakeholder groups	State government, health plans, providers, community groups, consumers
Member selection process	
Committees	Health information technology, quality improvement, communication, incentives
Advisory group	Consumer advisory group
Decision-making process	
Leadership	Chaired by Director and Health Officer for Public Health (Seattle & King County, Washington)
Staffing (including # FTEs)	9 staff: Executive Director, director of QI & administration, director of communication and development, director of health information, consumer engagement specialist, performance report analyst, research analyst, performance report project manager, committee coordinator
Budget	Receive public and private funding (almost 100% from participating organizations); recently received a $1 million grant from Robert Wood Johnson Foundation
MISSION & FUNCTIONS	
Mission	To build a strong alliance among patients, doctors, hospitals, employers, health plans and others to promote health and improve quality and affordability by reducing overuse, under-use and misuse of health care services. Facilitating a shift towards value-based purchasing in the state.
Major functions	Development of evidence-based clinical guidelines, public reports on quality of care, promotion of HIT and building of QI infrastructure, determine best practices in employer benefits management
Policy-making capabilities	None
Data collection	
Reporting	Public report on measures of quality, cost, and patient satisfaction updated quarterly
MAJOR INITIATIVES	
Accomplishments	Clinical Improvement reports, resources & tools for consumers & purchasers, regional report comparing health care performance (WA Community Checkup) available to public
Measurable results	

The following are examples of other existing quality and cost councils that may not be appropriate models for Colorado due to their narrow goals.

Alaska Health Care Strategies Planning Council

A council created in 2007 in an effort to develop a statewide plan to identify short– and long-term strategies addressing issues of access to, cost, and quality of health care.

Connecticut Quality Council

A non-profit organization affiliated with the University of Hartford, intended to offer a forum of exchange of information, networking, training, and best practices

Commission to Study Maine's Hospitals

A temporary commission created to conduct a report on a comprehensive analysis of hospital costs, roles, reimbursement, capital needs, and opportunities to make policy recommendations.

Iowa Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

A commission created by 2007 legislation to review, analyze, and make recommendations on issues relating to the affordability of health care for Iowans.

Minnesota Council of Health Plans

An association of eight licensed nonprofit health care organizations.

Minnesota Health Care Transformation Task Force

A task force created in 2007 to advise and assist the governor regarding health care system reform and to develop a statewide action plan improving health care affordability, quality, access, and outcomes.

Utah Health Data Committee

A committee within the Office of Health Care Statistics created to promote health transparency and quality by collecting and publishing health quality reports for consumers, as well as biennial reports on quality for policy-makers.

West Virginia Health Care Association

A trade association for extended care providers, and a state affiliate of the American Health Care Association. The association has 125 member facilities including nursing homes, assisted living communities, and hospital-based skilled nursing facilities.

Authors and Acknowledgements

This white paper was written by staff from JSI Research and Training Institute (JSI), including Elena Thomas Faulkner, MA; James Maxwell, PhD; Jaya Mathur, BA; Clancey Bateman, BA; Reesa Webb, MS; Susan Grantham, PhD; Laurie Kunches, PhD; and David Salinas, BA. Craig Stevens provided valuable information regarding quality forum efforts in Vermont.

JSI is a leading public health research and consulting organization with offices in Colorado, Massachusetts, New Hampshire, Vermont, Rhode Island, Georgia, Washington, D.C., and California.

JSI would like to thank all members of the CIVHC Steering Committee for their thoughtful discussion of and feedback on the findings related to this paper. Special thanks to the following people for their insights and suggestions in developing this white paper: Arja Adair, Colorado Foundation for Medical Care; Cody Belzley, Office of Governor Bill Ritter, Jr.; Crystal Berumen and Scott Anderson, Colorado Hospital Association, Vinita Biddle, Department of Personnel and Administration - Division of Human Resources; Joan Henneberry, Dr. Sandeep Wadhwa, Jenny Nate and Lesley Reeder, Department of Health Care Policy and Financing; Dr. Jay Krakovitz, Physician Health Partners; Dr. David Downs and Chet Seward, Colorado Medical Society; Marjie Harbrecht, Colorado Clinical Guidelines Collaborative; Dr. Mark Levine, Centers for Medicare and Medicaid Services; Jessica Sanchez, Colorado Community Health Network; Donna Marshall, Colorado Business Group on Health; Barbara Yondorf, Consultant to Rose Community Foundation. A special thanks also to leaders of quality forums in other states who took the time to share their insights with us: Josh Cutler, Maine Quality Forum; Brian Rosman, Health Care for All; Craig Jones, Vermont Blueprint for Health; Susan McDonald, Minnesota Governor's Office; and Katharine London, Massachusetts Health Care Quality and Cost Council.

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