HOW TO IMPROVE WISCONSIN'S HEALTH CARE VALUE

March, 2011

WISCONSIN WOMEN'S HEALTH FOUNDATION'S ANNUAL DIALOGUE

BENDING THE COST-CURVE…WISCONSIN STYLE:
HOW TO IMPROVE WISCONSIN'S HEALTH CARE VALUE

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About the Wisconsin Women's Health Foundation

Founded in 1997 by former first lady, Sue Ann Thompson, the Wisconsin Women's Health Foundation (WWHF) is a statewide non-profit organization whose mission is to help Wisconsin women and their families reach their healthiest potential. WWHF provides programs and conducts forums that focus on education, prevention, and early detection; connects individuals to health resources that directly address the greatest threats to women's health: cancer, cardiovascular disease, domestic abuse, mental illness, osteoporosis, and tobacco and alcohol use; produces and distributes the most up-to-date health education and resource materials; and, awards grants and scholarships to women health researchers and related community non-profits. To learn more, visit wwhf.org or call 1-800-448-5148.

WWHF's Annual Dialogue is a moderated panel discussion of state and nationally known health care specialists, legislators, business owners and the public to discuss the economic impact of health behaviors and issues.

Summary of the Health Care Challenge

Balancing quality, affordability, and access to health care in the United States has grown increasingly difficult as health care expenditures now account for 17%[1] of our national GDP. This has contributed to a growing uninsured population which now numbers more than 50 million[2]. In addition, premiums continue to skyrocket as employer-sponsored family health insurance premiums rose by 119 percent nationally, between 1999 and 2008, while median family income rose by 29 percent.[3] All of this is evidence of an out-of-control health insurance system that is simply unsustainable.

Health premiums in Wisconsin over the last decade have risen a staggering 179% vs. only 120% in the remainder of the U.S.

In 2008, the Agency for Healthcare Research and Quality (AHRQ) ranked Wisconsin first in the nation for health care quality, although it slipped to second in 2009[4]. Wisconsin also ranks third in its access to health insurance with the third lowest rate of uninsured residents[5].

These are dramatic illustrations of the commitment to quality healthcare that exists in Wisconsin emphasizing access to health care as an essential component of our quality of life. Wisconsin has worked hard to provide access to quality health insurance.

However, that tremendous access and quality has come at a price. Wisconsin's health insurance premiums have risen far faster than the remainder of the United States. Premiums over the last decade have risen a staggering 179% in Wisconsin versus *only* 120% in the remainder of the U.S.[6]

[1] Kaiser Family Foundation, http://www.kff.org/insurance/upload/7692_02.pdf

[2] Kaiser Health News Service, http://www.kaiserhealthnews.org/Stories/2010/September/16/census-uninsured-rate-soars.aspx

[3] The Commonwealth Fund, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf

[4] United States Agency for Healthcare Research and Quality, http://www.ahrq.gov/about evaluations/partnerships/partnerships.pdf

[5] United States Census Bureau, http://www.census.gov/compendia/statab/cats/health_nutrition/health_insurance.html

[6] Kaiser Family Foundation and Health Research & Educational Trust, *Employee Health Benefits 2009*, (September 2009).

There is little doubt that Wisconsin has been an innovative leader in social policy dating back to the early 1900s on issues as diverse as establishing the first state worker's compensation system to establishing the first kindergarten. More recently Wisconsin has successfully revised its welfare system and enhanced health insurance access through the implementation of BadgerCare. Now, Wisconsin is a leader on health care quality and access to health insurance. This is not enough however, as evidenced by the staggering health insurance premiums our businesses and individual residents see annually. It is time for Wisconsin again to take the lead; this dialogue is the Wisconsin Women's Health Foundation's challenge as a first step toward the goal of achieving true health care value.

Background and Opening Remarks

On September 14, 2010 the Wisconsin Women's Health Foundation held their 5th Annual Dialogue bringing together five unique Wisconsin organizations whose focus is improving Wisconsin's health care value. These organizations are:

- Agency for Healthcare Research and Quality (AHRQ)
  Dr. Carolyn Clancy, Director
- Wisconsin Academy of Family Physicians (WAFP)
  Larry Pheifer, Executive Director
- Wisconsin Health Information Organization (WHIO)
  Jo Musser, Vice President
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
  Chris Queram, President
- Marshfield Clinic
  Dr. Douglas Reding, Clinic Vice President
- The Alliance
  Cheryl DeMars- President and CEO

The dialogue moderator, Nino Amato, president and executive director of the Coalition of Wisconsin Aging Groups, kicked off the event with a description of a 1986 book by Dr. Theodore Seuss Geisel, "You're Only Old Once", on the inefficiency and problems within American healthcare. This was a poignant jumping off point for the discussion as little has changed since the 1980s except for higher insurance premiums. Dr. Seuss' whimsical portrayal of American

health care's inefficiency rang loudly among the audience even as Wisconsin stands at the forefront of quality initiatives.

Dr. Carolyn Clancy of the Agency for Healthcare Research and Quality touted Wisconsin's position as the #2 state in both health care quality and access to health insurance, but insisted that more can be done and to not rest on our laurels. Clancy noted that Wisconsin is a long-time leader as an active "laboratory for healthcare innovation." She noted that an emphasis needs to be placed on lowering the health care costs for the 20% of society who endure multiple chronic illnesses as they account for between 72-80% of healthcare expenditures.

Clancy announced that a national strategy for improving health care quality will be delivered to the U.S. Congress in January 2011 by Secretary of the Department of Health and Human Services, Kathleen Sebelius. That quality effort will espouse a broad framework to foster better healthcare, at an affordable cost, and account for regional differences. [**Note: The National Strategy for Quality Improvement in Health Care was released on March 21, 2011. WWHF delayed distribution of this White Paper in order to include this information. See page 17 for a summary of the strategy and for links to review the entire document.**]

The National Strategy for Quality Improvement in Health Care was released on March 21, 2011 by the U.S. Department of Health & Human Services. See page 17 of this White Paper or visit www.hhs.gov/news.

LARRY PHEIFER, WAFP

Larry Pheifer discussed the Patient-Centered Medical Home (PCMH) project and the Wisconsin Academy of Family Physicians' (WAFP) additional initiatives focused on improving quality and efficiency in primary healthcare. WAFP's initiatives include:

- Department of Health Services Patient-Centered Medical Home pilot project centered on high risk obstetrics.
- Patient-Centered Medical Home Multi-Stakeholder demonstration project
- Wisconsin Payment Reform Initiative

These initiatives are focused on enhancing the availability of primary care services because WAFP has demonstrated 33% savings in cost and better outcomes when primary care physicians are involved.

The PCMH pilot is built on the premise that patients develop improved relationships with their family physician, leading to improved health outcomes. The PCMH concept transforms the office into a venue that is convenient for the patient with a whole person orientation. According to the WAFP Web site, the PCMH model is succeeding in Menominee, WI where Dr. David Eitrheim, a family practice physician, is embracing a team approach where nurses and other members of the staff manage patient education and documentation, freeing him to concentrate on what he does best. "It has reinvigorated our practice," says Dr. Eitrheim.

WHIO looks at process measures and percentage of patients that received care to help physicians measure their cost effectiveness.

It is a win/win result where:

- Patient wait times are down.
- Nurses are more satisfied.
- Physicians are more satisfied.

The PCMH model focuses on quality and performance measurement with systems to illustrate the progress or decline in care. The model includes open access with 70% of physicians having an open and flexible schedule. If a patient misses an appointment there is follow-up to ensure care coordination and primary care physicians coordinate with specialists to ensure good communication.

JO MUSSER, WHIO

The Wisconsin Health Information Organization (WHIO) is a voluntary initiative supported by visionary leaders from insurance companies, health care providers, major employers, and public agencies who share a commitment to the future of health care. WHIO holds an unprecedented volume of data comprising more than 136 million claims for care provided to 2.8 million Wisconsin residents. In October 2010 the database grew to include approximately 3.3 million lives. A total of more than 11 million episodes of care are now found within the WHIO

database. An episode of care is defined as a series of treatments and follow-up related to a single medical event such as a broken leg or heart surgery.

The founding members of the WHIO include Wisconsin's five largest insurers (Anthem, WPS, Humana, WEA Trust and United Healthcare) and the Wisconsin Medical Society, Wisconsin Medical College, and others.

WHIO's mission is to collect, aggregate, and disseminate claims information to allow physicians to measure their performance and improve the cost-effectiveness through peer comparisons.

WHIO looks at process measures and what percentage of patients received the care they needed, creating vital information that is important for physicians to understand their cost effectiveness.

Through the WHIO database analysis it is possible to look at episode of care costs and compare outcomes peer to peer.

CHRIS QUERAM, WCHQ

The Wisconsin Collaborative for Healthcare Quality (WCHQ) focuses its quality improvement efforts toward clinical outcomes. WCHQ assesses these outcomes by comparing hospital readmissions against their peers. This provides hospitals the opportunity to assess its processes and learn why their readmissions are higher than average. The hospitals are able to eliminate other intervening variables as well such as whether their patient population has a lower overall quality of health versus peer hospitals. This allows as great an apples-to-apples comparison as possible.

As an example, Queram cited that one hospital member of WCHQ learned their readmission rate was 46% higher than their peers and was able to plan and implement strategies to address this costly discrepancy. In addition, WCHQ members are also able to compare commercial outcomes against Medicaid outcomes. Provider organizations as well as WCHQ are in the process of working with the WHIO data and developing it to the point where it can be used in conjunction with the clinical quality measures.

WCHQ Example: Angioplasty costs have a four-fold difference among two clinics in close proximity. Geographic costs differences did not play a part in these divergent costs. Also, it was shown that on average, patients in the more cost-effective group actually were of poorer health than the more costly clinical group. Through these mechanisms it can be illustrated which physicians are contributing to the increased costs. WCHQ combines that cost data with quality indicators measuring hospital and other providers' effectiveness to determine the best value for specific conditions, surgical procedures, and other episodes of care. These analyses are then shared among member organizations so that best practices can be spread and utilized as widely as possible to improve the health care value across Wisconsin.

The state of Wisconsin requires that plans participating in the state employee health insurance program also participate in the WHIO database to aide those state employees in choosing their individual health plans.

DR. DOUGLAS READING, MARSHFIELD CLINIC

Dr. Douglas Reding noted Wisconsin's long history of leading healthcare redesign indicating that Wisconsin has been a leader in the effort prior to the advent of Medicare. To improve the future of healthcare, Reding suggested that redesign must focus on quality, access, and reduced costs. Marshfield Clinic, with 780 providers in 53 service centers, sees as its mission the provision of accessible care, high quality research, and education reducing burden of disease for its patients and communities.

According to Reding, Electronic Medical Records (EMR) are an essential tool to be a better provider and manager of chronic care as the EMR is a mechanism to ensure better preventive services. Some of the means by which EMRs can improve the provision of care cited by Reding include:

- Make immunization records more accessible to other providers
- Make allergy information more accessible
- Make it easier to identify negative drug interactions

Reding noted results from Marshfield Clinic's quality demonstration project under the Centers for Medicare and Medicaid Services (CMS) which sought to improve efficiency of care while maintaining quality. The project required Marshfield Clinic to demonstrate 2% savings while meeting quality metrics. In the first year of the project, Marshfield Clinic focused on diabetes management; in the second year, cardiac care. The end result was that Marshfield Clinic demonstrated 98% improvement and saved CMS $48 million.

Reding stated that reform of health care needs to focus on patients with more critical needs, engaging payors in reimbursing better care, with a continual focus on better quality leading to an overall better focus on population and community health.

CHERYL DEMARS, THE ALLIANCE

Cheryl DeMars heads a cooperative of employers organized to pool their purchase of health care benefits with improved quality and value than they would otherwise achieve on their own in the marketplace.

The Alliance strives to:

- Control health care costs
- Improve quality
- Engage employees in improving health

Employer members of the cooperative don't purchase insurance; rather they engage employees in health care and financing decisions.

The Alliance's mission centers on the efficient purchase of quality health care services for its membership. They work to achieve additional cost savings for its members through wellness and other programs that directly benefit employees, but also benefit employers through reduced healthcare costs of healthier employees. The Alliance does not achieve savings by cutting benefits or shifting costs through higher deductibles or coinsurance levels to employees.

The Alliance's bending of the cost curve strategy seeks to use cost and quality information effectively by the following means:

- Share cost and quality data with employees.
- Our #2 status does not mean everyone gets THE best care.
- Job #1 is to use available information to improve employee options.
- Use The Alliance's ***QualityCounts™*** reports to help members learn more about the quality and cost of care. This report provides cost information for a number of outpatient procedures and tests at facilities that belong to The Alliance network.
- Pass savings to employees to provide better health incentives.

DeMars gave an example of the data available through the WCHQ. She cited the range of costs of a normal delivery ranging from a low of $3,054 through one provider as compared to $8,964 at another provider. DeMars concluded, "That's a huge disparity for the same care, with the same risks. The database is an important tool for employers in making purchase decisions."

DeMars further noted that payment reform needs to incorporate incentives aligning higher reimbursement with quality outcomes. In this way, employers need to insist on better health outcomes for their employees. In addition, DeMars argued for an increased focus on wellness, as The Alliance has done, to promote and improve individual employee health. She said the pressure must be for constant improvement, don't rest on our laurels, don't celebrate 80% achievement, even when you're the best there's always room to improve.

Bending the Cost Curve Dialogue and Questions to Panelists

NINO AMATO, MODERATOR

Amato noted that the health care reform discussion began not under President Clinton in the 1990s, but with President Theodore Roosevelt. We face the same issues today as were discussed in that policy debate 100 or so years ago (safety, access, and cost), and thus we need sustainable, cost effective access, and outcomes.

What's driving healthcare costs up? Many reasons: consumers aren't rewarded for staying healthy; defensive medicine; lack of quality and process measures; lack of focus on evidence-based care…

DR. CAROLYN CLANCY, AHRQ

Wisconsin is a long-time leader and laboratory on health care. Wisconsin and other states can utilize the research findings from Comparative Effectiveness Research to build on best practices and improve care, especially for those with multiple chronic illnesses. For instance, Clancy noted that we don't do well on diabetes and for those with more than one chronic illness; and if one of those chronic illnesses is mental illness, it is much more challenging. This disparity can no longer be tolerated. We've got to do better at making the right thing easier to do.

What is driving healthcare costs up?

Musser: No single thing. Consumers are not rewarded for staying healthy; in our current system, we only receive benefits when we're sick. We need to create informed decisions that allow patients and their physicians to collaborate toward best practice outcomes. Today, physicians have the wrong incentives: more care = more dollars. Rewards need to be in the right places. Quality and process

measures are the place to start to get everyone the care needed to achieve the best quality possible and the biggest challenge is to get consumers involved.

Queram: The emphasis needs to be on defining quality; right patient, right time, and right place, at the right cost. Improve quality to reverse the current cost trend – a huge problem is the professional autonomy in the industry. Transparency is the key to removing cost disparity and using available decision support tools seen in the peer research.

Another must is the need to address the provider and cultural transformation in health care. Until that's improved, disparities will remain. Our current fee-for-service system creates overutilization. New technology creates opportunities for improved outcomes. New technology does have costs though, but costs are also driven by defensive medicine.

Pheifer: Payment reform is needed to realign incentives. The focus needs to be moved to primary care. There needs to be an increased focus on evidence-based care.

DeMars: We need better coordination for the patient; better communication is the key to more efficient care.

Reding: We need better coordination and communication; if something is missed it could be the linchpin. We need to make sure communication is the best possible to achieve the best outcomes.

➡ **How might these efforts improve mental health care, in particular now that mental health parity has been enacted?**

Pheifer: On the issue of mental health, HIPAA, despite good intentions can get in the way of proper information-sharing among treatment providers. In addition, Milwaukee County has found the means to identify emergency room repeaters and foster more efficient care by discussing with patients the appropriate use of urgent care and other accessible treatment.

Musser: Mental health stigma gets in the way and has created a different treatment discussion. Parity needs to be real. Mental health parity allows unfettered mental health visits that will drive up costs; it is a chronic long- term treatment.

DeMars: Mental health needs to be the focus of the federal comparative effectiveness research effort. Employers need to know what to pay for and to judiciously pay for care.

➡ **Given the passage of the federal health care reform, how can Wisconsin build on it and achieve payment reform?** (Question submitted by Senator Mark Miller)

Musser: Payment reform initiatives need to address primary and chronic care. The PPACA creates opportunity for payment reform discussion and three possible options:

1) Shared savings model like Marshfield Clinic has done (as described during Dr. Reding's presentation)
2) Partial capitation option provide global payment for a disease state (diabetes specified for instance)
3) Provider contracts create difficulty in instituting payment reform, but WHIO has been redesigning a payment system that reimburses behavior change and pays for high-value care. It will be piloted in 2011.

Dental issues are the #1 reason for school absence.

Queram: Building on what Jo Musser described with the voluntary committee establishing the payment reform mechanism, it is absolutely great that Wisconsin's Department of Health Services and the state Medicaid program are involved.

Reding: Payment reform needs to be a hybrid answer and part of a larger multi-faceted approach; it is not a sliver bullet.

➡ **There is a wide-variation in dental access in Wisconsin. How can access to dental care be improved as a component of this discussion?**

Reding: Marshfield dental clinics are expanding across northern and central Wisconsin and serving at-risk populations. In 2008, through the BadgerCare Plus program, Wisconsin invested $8.8 million to expand access to dental care for children and families. Marshfield Clinic has also created an Electronic Dental Record to better improve access to dental records among providers.

Queram: Comprehensive health reform needs to focus on dental as well as medical. We need a holistic look at redesign focusing on global, all-inclusive care.

Musser: The United Way Community solutions initiative looks at dental access everywhere. Dental issues are the #1 reason for school absence. The #1 barrier is too few pediatric dentists.

Pheifer: The concept of the medical home needs to be expanded to medical neighborhood which would include dental.

➡ **In the context of Wisconsin's current budget crisis, what can be done since extra money to use for better primary care is not available? It seems that increased efficiency is the key. What about reimbursement based on better results?** (Question submitted by Senator Mark Miller)

DeMars: It begins by putting it in provider contracts. For instance, the better health outcome is a normal delivery, not a C-Section. Within its contracts, The Alliance is rewarding providers with better reimbursement when they bring their C-Section rate down.

➡ **How might consumers benefit from WHIO data usage?**

Musser: The 2010 focus with the WHIO database is on providers so they can use it better to improve care and outcomes. In 2011 we will begin a contract with the Wisconsin Department of Health Services to provide consumers with the WHIO data through a dedicated consumer website with summarized and interpreted data. It will be free of medical-speak and user friendly.

Reding: The data needs to reflect the patient populations and we need to ensure that it's truly comparable with all variables and standard metrics.

Musser: WHIO was formed to streamline measures because physician comparisons were going to be a given. We identify areas for improvement vs. peer groups. It is assured that the rules are the same for the entire peer group so that the scores are as accurate as possible.

Queram: Consumer engagement has a long way to go; "If you build it they will come", is not working so far. WCHQ is not getting consumer engagement at this point.

Amato: The Campaign for Better Care may be the best way to get consumer involvement. It is an organization that is striving to make patient-centered care work for all Wisconsin residents. In the age of social media, Twitter and Facebook seem to be the way to get consumers' attention.

Only 8% of medical students are going into primary care; most are specializing for a variety of reasons, but paying off students loans seems to be a catalyst to entering a more lucrative medical career.

➡ **In regard to other social issues especially child abuse, can health reform increase screening and detection?**

Musser: There was a campaign for screening for domestic violence with support from WPS Health Insurance to put screening questions in the hands of physicians. The key is to have proper referrals. This also feeds the need for better mental health coordination since it should be tied to domestic violence screening so that kids get appropriate help and victim counseling.

Queram: We need to think beyond medical care; there is so much more involved. For instance in the educational system, when guidance counselors are exposed to this, they need to be part of the referral process. But again, it goes back to the shortage of primary care providers.

Pheifer: [During the time of the Dialogue], there are 147 openings for primary care physicians; most of these openings are in rural areas. Is there a shortage, or is it a distribution problem? Six years ago there were 62 and Wisconsin had a good medical liability climate. There just aren't enough doctors graduating in

primary care; only 8% of medical students are going into it. With student loans in excess of $200,000 that serves as a catalyst to specialty care where more money is made. There is loan repayment available but more is needed; we need to promote loan repayment programs through the legislature. The University of Minnesota-Duluth attracts to its medical school primary care docs; that's what they aim for. UW Madison, on the other hand is known for research so we target specialists. In addition, medical students are sometimes told they're too smart to be primary doctors.

➡ **How can the implementation of health care reform be utilized to include payment reforms and increase health plan and healthcare efficiency? Can Accountable Care Organizations (ACOs) be implemented widely?**

Musser: In 2013 the Health Insurance Exchanges (HIE) will be implemented in the individual health plan market. HIRSP rates have also improved as a stop gap mechanism prior to HIE implementation. Payment reform based on an episode of care could be tried in limited test-pilots. In early 2010 a group of interested parties convened to organize the development of pilot payment reform initiatives. The pilots are scheduled for early 2011.

We need the energy and commitment of individuals to move forward and advance the cause with elected leaders and health care decision-makers to implement mechanisms focused on improving quality of care and maximizing resources.

Reding: Episode of care based payment reform is difficult on a statewide basis; pilots could be done on a geographic basis.

Musser: ACOs are Medicare based. ACOs are too far of a stretch from where we stand today. The HIEs are an opportunity for consumers to select the best plans. Provider contracts that exist today are fee-for-service based; the HIEs can't affect that. Payment reform needs to be on a pilot basis with an incremental reform approach. The Wisconsin payment reform initiative is looking at three mechanisms; we're working right now on what it will look like with an emphasis on chronic care, specifically childhood asthma and diabetes. The ultimate goal is implementation.

Moving Forward/Next Steps

Wisconsin is uniquely positioned to build upon its quality and access rankings with forward-thinking and effective organizations such as the Wisconsin Collaborative for Healthcare Quality, the Wisconsin Health Information Organization, the Wisconsin Academy of Family Physicians, Marshfield Clinic, and The Alliance working collaboratively. The promise of health care reform, in all its controversy, and amid a myriad of potential consequences, can succeed in Wisconsin with these groups and others focused on improving quality healthcare delivery and outcomes. Wisconsin has proven its ability to innovate; we again can lead the nation forward and be the laboratory for quality-focused health care reform implementation. The tools are here, and the engineers to accomplish it are among us, as evidenced by this dialogue. With all that in place, what is needed most now is the energy and commitment to move forward and advance the cause with elected leaders and health care decision-makers to implement mechanisms focused on improving quality of care and maximizing resources.

If you agree, contact your legislator and get involved by contacting the resources listed on page 19.

The Wisconsin Women's Health Foundation is committed to being a part of this ongoing discussion. In addition to incorporating proven mechanisms into our statewide outreach programs which focus on education and prevention and early detection of diseases that affect women the most, we will continue to communicate information about this topic in our newsletters and on our Web site.

It is time for Wisconsin to use its position as a health care quality leader to truly create health care value. That process starts with all of us moving forward.

National Quality Strategy – U.S. Department of Health & Human Services

Below is a press release issued March 21, 2011 by the U.S. Department of Health & Human Services summarizing their National Strategy for Quality Improvement in Health Care.

March 21, 2011 – The U.S. Department of Health & Human Services (HHS) today released the National Strategy for Quality Improvement in Health Care (National Quality Strategy). The strategy was called for under the Affordable Care Act and is the first effort to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care in the U.S.

"The Affordable Care Act sets America on a path toward a higher quality health care system so we stop doing things that don't work for patients and start doing more of the things that do work," said HHS Secretary Kathleen Sebelius. "American hospitals, doctors, nurses and other health care providers are among the best in the world. With this ground-breaking strategy, we are working with local communities and health care providers to help patients and improve the health of all Americans."

The National Quality Strategy will promote quality health care that is focused on the needs of patients, families, and communities. At the same time, the strategy is designed to move the system to work better for doctors and other health care providers – reducing their administrative burdens and helping them collaborate to improve care. The strategy presents three aims for the health care system:

- Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- Healthy People and Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

To help achieve these aims, the strategy also establishes six priorities, to help focus efforts by public and private partners. Those priorities are:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The strategy was developed both through evidence-based results of the latest research and a collaborative transparent process that included input from a wide range of stakeholders across the health care system, including federal and state agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. This process of engagement will continue in 2011 and beyond.

The National Quality Strategy is designed to be an evolving guide for the nation as we continue to move forward with efforts to measure and improve health and health care quality. HHS will continue to work with stakeholders to create specific quantitative goals and measures for each of these priorities. In addition, as different communities have different needs and assets, the strategy and HHS will empower them to take different paths to achieving these goals.

The National Quality Strategy is just one piece of a broader effort by the Obama Administration to improve the quality of health care, and will serve as a tool to better coordinate quality initiatives between public and private partners. For example, the Affordable Care Act established a new Center for Medicare and Medicaid Innovation that will test innovative care and service delivery models. These new models are being tested to determine if they will improve the quality of care and reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Read the report at www.HealthCare.gov/center/reports. For more information about the National Quality Strategy, visit www.ahrq.gov/workingforquality/.

Additional Resources

There are numerous Wisconsin entities working right now to move health care quality and effectiveness to new heights. These include:

- Agency for Healthcare Research and Quality (AHRQ)
  http://www.ahrq.gov/
- The Alliance
  http://the-alliance.org/
- The Campaign for Better Care (Wisconsin)
  http://www.cwag.org/advocacy-legislation/wicampaignforbettercare/
- Marshfield Clinic
  http://www.marshfieldclinic.org/patients/
- The Patient-Centered Primary Care Collaborative
  http://wwww.pcpcc.net
- United Health Group, Center for Health Reform and Modernization
  http://www.unitedhealthgroup.com/newsroom/news.aspx?id=1254ceff-411d-47dc-8ac0-2c3b4e4790c2
- Wisconsin Health Information Organization (WHIO)
  http://www.wisconsinhealthinfo.org/
- Wisconsin Payment Reform Initiative (WPRI)
  http://www.wha.org/education/pdf/2010wispaymentreform.pdf
- Wisconsin Academy of Family Physicians (WAFP)
  http://www.wafp.org/
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
  http://www.wchq.org/
- Wisconsin Primary Health Care Association
  http://www.wphca.org/