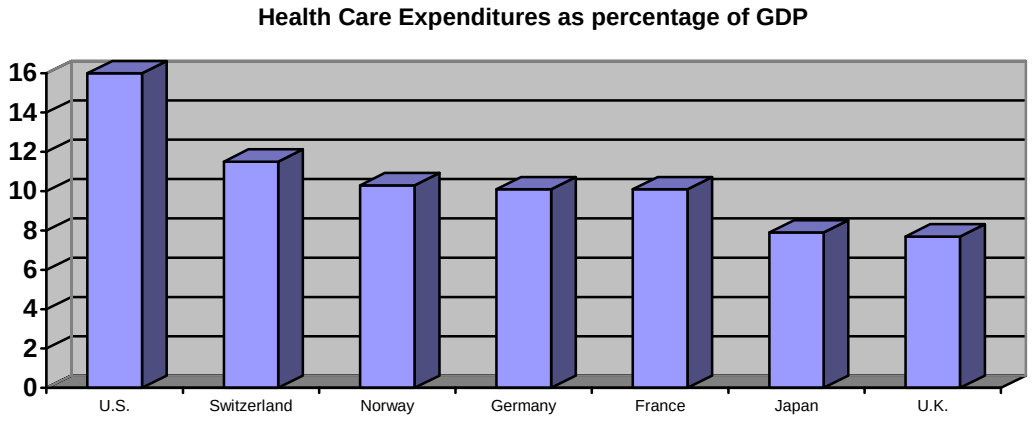
# Health Care Quality Improvement: Opportunities for Governors

**States and Health Care Quality Improvement: A Call to Action**

The quality of health care delivered in America does not justify the resources that health care services consume. Health care spending represents 16 percent of the U.S. Gross Domestic Product (GDP)—a far greater share than in any other industrialized nation. On a per-capita basis, Americans spend $5,635 for health care—53 percent more than citizens in any other country, and 140 percent more than the mean per capita spending for industrialized nations.[1] This pattern of spending is likely to increase for the foreseeable future, placing other spending priorities at risk for employers, individuals, and governments. If current trends continue, the U.S. will spend 21 percent of its GDP on health care by the year 2020.




***The Problem***

However, the United States does not enjoy higher levels of healthcare quality than its lower spending counterparts. American life expectancy is exceeded in 21 other countries; Infant mortality in the United States is the fifth highest of any industrialized country; More cancer cases per 100,000 people are reported in America than in half of industrialized nations; And the United States has the highest obesity rate in the industrialized world.[2]

A recent study by the Commonwealth Fund compared patient experience in five nations: Australia, Canada New Zealand, the United Kingdom, and the United States. While the US received high marks for effectiveness—basing health care decisions on the best scientific available knowledge—it ranked last in quality overall. In other words, while the US pioneers new health care interventions, it fails to use them consistently. According to the survey results, Americans are more likely to receive the wrong medication than patients in any of the other five countries, are more likely to visit an emergency room for a condition that could have been treated in a doctor's office, and are least likely to consider their care to be patient-centered. Americans with low incomes were significantly more likely to go without needed care as compared with low income citizens of other countries.

**International Rankings of Health Care and National Health Expenditures**

| | Germany | New Zealand | United Kingdom | Australia | Canada | United States |
|---|---|---|---|---|---|---|
| **Overall Ranking** | 1 | 2 | 3 | 4 | 5 | 6 |
| **Patient Safety** | 2 | 3 | 1 | 4 | 5 | 6 |
| **Effectiveness** | 3 | 6 | 5 | 3 | 2 | 1 |
| **Patient-Centeredness** | 1 | 2 | 4 | 4 | 5 | 6 |
| **Timeliness** | 1 | 2 | 5 | 4 | 6 | 3 |
| **Efficiency** | 1 | 2 | 3 | 4 | 5 | 6 |
| **Equity** | 5 | 1 | 1 | 2 | 4 | 6 |
| **Health Expenditures per Capita** | $2,996 | $1,886 | $2,231 | $2,903 | $3,003 | $5,635 |

*The Commonwealth Fund, "US Ranks Poorly in Cross-National Patient Surveys." April 2006.

Even more surprising, within the United States, evidence demonstrates that higher spending regions—with higher utilization rates—often experience lower quality health outcomes. A recent study of Medicare spending levels by each state demonstrated this sometimes inverse relationship between health care spending and health care quality. According to the study, Medicare enrollees in regions with more intensive provision of care had slightly worse access to services, were less satisfied with their care, and received demonstrably lower care quality. In fact, Medicare costs vary twofold across regions in the country—with no relation to differences in price or illness rates among populations. [3]

New evidence of both patient safety and care quality raise even more serious concerns about the quality of the health care that Americans receive.

- More than 57 thousand patients die because they did not receive appropriate health care and between 44 and 68 thousand die as the result of a preventable medical error each year—more than the number of people killed in motor vehicle accidents.[4]
- Patients receive only 55 percent of care recommended for their respective health conditions.[5]
- Less than half of the recommended care management processes for four of the most prevalent chronic diseases are used routinely by physician organizations.[6]
- As many as 18,000 people die annually from heart attacks because they were not prescribed a drug that could have prevented the attack—even though they were eligible to receive the prescription.[7]
- Two in five diabetics do not receive an annual eye examination to check for signs of conditions that lead to blindness, and almost half do not receive a foot exam to check for nerve damage—both of which can be treated to prevent or slow degeneration.[8]

The great variation of quality—as well as the fact that some higher spending regions with greater intensity of health care delivery produce worse health outcomes—highlights the profound impact

that quality variation could have in the health care system.[9] Some evidence suggests that as much as 30 percent of health care spending in the U.S. could be the result of care that does not improve a patient's health.[10] For example, an analysis published by the Agency for Health Care Research and Quality (AHRQ) found no difference in outcomes between patients who did and did not undergo routine preoperative testing before cataract surgery. Such testing costs Medicare approximately $150 million each year.

> *Medicare costs vary twofold across regions in the country with no relation to differences in price or illness rates among populations.—* Dartmouth Medical School

In short, Americans do not receive the value that would be expected for the cost of the services that they pay for. The standard of care delivered in the U.S. health care system must be improved. By avoiding unnecessary or harmful care as well as delivering appropriate care in the first place, dollars and lives could be saved immediately—and future health care needs could be avoided. Getting more for the money that Americans spend on health care is essential if access to affordable care is to be achieved for all—or even for current levels to be maintained.

**What is Health Care Quality?**

Put simply, the US Department of Health and Human Services states "quality health care means doing the right thing, at the right time, in the right way, for the right person—and having the best possible results."[11] Specifically, the Institute of Medicine (IOM) states that health care delivery should be[12]:

- **Safe**. Avoids injuries to patients.
- **Effective**. Based on scientific knowledge.
- **Patient-Centered**. Patient values guide clinical decisions.
- **Timely**. Reduces waits and harmful delays.
- **Efficient**. Avoids waste of equipment, supplies, ideas, and energy.
- **Equitable**. Does not vary based on personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Most of the problems that prevent this ideal vision of health care fall into three categories:

- **Overuse**. Providing a service when its potential for harm exceeds the possible benefit.
- **Underuse**. Failure to provide a service when it would have produced a favorable outcome.
- **Misuse**. Providing an appropriate service, but when a preventable complication occurs, the patient does not receive the full potential benefit of the service.[13]

> *"Quality health care means doing the right thing, at the right time, in the right way, for the right person—and having the best possible results."—* AHRQ

**Why is Health Care Quality Poor?**

Quality deficiency in the U.S. health system can largely be attributed to the system itself—which is designed to treat the acute care needs of patients, with little emphasis on or support for prevention or care continuity. Adding to the complexity, the system is funded by a variety of public and private payers, at the local, state, and federal level. Historical records of patient health data are kept largely on paper that is scattered across a fragmented system of providers and health care organizations. Clinical standards and protocols for care vary widely across the provider community. New evidence based treatment guidelines diffuse slowly throughout the health

system—taking an average of 20 years from development before becoming standard clinical practice.[14]

Perhaps most importantly, patients have little support for or incentive to manage their own care and have little access to information for choosing providers that deliver the best quality services for the best price. While measurement standards exist to compare health plans, little quality measurement occurs at the provider level—and even less is publicly reported. As employers and insurers move toward consumer driven models of health care coverage and higher levels of employee cost sharing, patients will need access to provider specific quality information, ownership of their own medical record and clinical history, and access to support services not considered part of the traditional medical model. When considered against the trends of chronic disease prevalence, the quality of America's health care will decline further unless the system of care delivery is changed.

**A Role for States—and Governors**

While most of the debate about health care and health reform has traditionally occurred at the national level, much of the real progress has occurred in the states. State governments have lead the way in coverage expansion—particularly for children and families. They have used innovative discount and subsidy programs to provide pharmaceutical benefits to scores of low-income seniors at a time when Medicare provided no outpatient prescription drug benefits at all. They have maintained coverage for tens of millions of low-income Americans during times of negative revenue growth. And they have been pioneers in linking quality improvement to cost reduction through the development of disease management programs to improve health outcomes for Medicaid beneficiaries. Governors in particular can play a major role in leading initiatives to house measurement data and creating data sharing and transparency agreements across multiple stakeholders.

> *A Recent AHRQ study found no difference in outcomes between patients who did and did not undergo routine preoperative testing before cataract surgery. Such testing costs Medicare approximately $150 million each year.*—Institute of Medicine

***Why Should Governors be Involved in Health Care Quality?***

Most state constitutions hold that one of the most essential gubernatorial responsibilities is to protect the health and welfare of the state's citizens. Much of people's health and welfare is tied directly to the health care system itself: how well it treats them, how much it costs, how accessible it is, and how it affects their ability to find employment.

Governors have strong economic and financial incentives to improve the quality of health care in their states. Ultimately, states will face the difficult budgetary trade-offs that will continue as health care spending outpaces revenue growth. If access is to be improved—or even maintained—and costs are to be managed, greater value must be achieved within existing resources.

Health care quality improvement will become essential to encourage new business growth—and to recruit companies that are expanding or relocating. As the cost and consequences of poor health outcomes consume a larger share of company profits and worker salaries, businesses will have no choice but to consider the cost and quality of health care delivery before making decisions about where to invest. Further, states with higher performing health care systems will be more likely to recruit high performing health care workers.

Beyond such practical concerns, governors are unique in their responsibility for population health quality. As managers of complex public health infrastructures with tasks ranging from monitoring immunization rates and the spread of infectious disease to responding to the threat of bioterrorism, governors represent the point at which the public health and health care systems must communicate effectively according to the same set of priorities.

***How Could a Governor Pursue a Health Care Quality Agenda?***

Governors are the Chief Executive Officers (CEOs) of organizations that are the right size and scale for such intervention. States are small enough to understand community level quality variations and what causes them—but are large enough in their scope of governing authority to change many regulatory and financing mechanisms that underpin the delivery of health care. Governors in particular possess many of the necessary tools and much of the authority to drive an aggressive and comprehensive quality improvement agenda. Four key state levers provide a map for taking state action.

**Setting a Common Vision**

Whether viewed as a cause for or consequence of the fragmented US health care system, the lack of a common vision for health care quality complicates quality improvement initiatives at all levels of care. In defining quality health care and its impediments, the IOM has consistently called for public policy leaders to define a vision for quality health care and articulating a quality improvement strategy across stakeholders. Governors are well positioned to set and articulate such a vision—and to communicate it to the public.

This vision could include:

- Creating a clear image of the benefits of quality health care—and the consequences of poor quality—according to quality of life and life span.
- Establishing system priorities, such as patient safety or care for the chronically ill.
- Using the 'bully pulpit' to build public support for policy initiatives that address quality improvement in targeted areas.
- Applying public pressure to low-performing providers or institutions—or to those unwilling to publish price and quality information for the services that they provide.

**Convening Key Stakeholders**

Once a vision has been agreed upon, Governors are unique in their ability to convene the relevant and necessary stakeholders to determine, agree upon, adopt, and implement a coordinated quality improvement initiative. As many health plans and provider groups are prohibited from gathering on their own to share and measure health data under federal anti-trust laws, gubernatorial convening of relevant entities to set common quality measures and quality improvement techniques is a key benefit to state-lead initiatives. Further, state-facilitated collection and public reporting of health quality data could be a profound boost to systemic transparency.

Specifically, governors could use their convening authority to drive consensus of key stakeholders in order to:

- Agree on and prioritize quality improvement strategies and specific techniques, such as care coordination for chronic disease.
- Agree on common sets of measures and reporting protocols.
- Agree on public disclosure of quality and price data—and encourage system transparency.

- Facilitate shared knowledge and free flow of information—particularly between patients and clinicians.
- Agree on evidence based standards of care—and establish standard processes for evidence based decision making that reduce variation in treatment and utilization and help providers synthesize new medical science more quickly.

**Regulation of Providers and Insurers**

Many of the rules and regulations governing providers—as well as the health care system itself—are determined at the state level. States regulate health plans. Many states set health care quality reporting requirements for Health Management Organizations (HMOs) and other managed care plans. States license physicians, pharmacists, nurses, hospitals, long-term care facilities, and ambulatory care clinics. And states create and implement medical liability rules and medical error reporting systems, as well as malpractice insurance itself.

State regulation can be a powerful tool to promote continuous quality improvement. Changes to state regulation could include:

- Establishing patient safety authorities for reporting and identifying systems failures through non-legal processes.
- Altering provider practice acts to give non-physician providers the necessary permission to provide care coordination—and to receive reimbursement for non-medical services that decrease the need for more expensive clinical interventions in the future.
- Requiring public reporting of quality measurement and price data for state facilities and state-regulated health plans, including Preferred Provider Organizations (PPOs) and traditional fee-for-service plans.
- Establishing processes for provider licensure and certification that support lifelong learning and ongoing competency and that recognize a provider's need for new information.
- Removing regulatory barriers relating to the exchange of clinical information through electronic prescribing, electronic medical records, and patient-physician communication online—and creating interoperability between clinical data and public health surveillance.
- Simplifying billing and coding procedures so that more accurate comparisons can be made among similar procedures and treatments—and to reduce provider administrative burden.
- Integrating care coordination and cross-clinician team approaches to care with existing medical school curriculum at state-funded institutions of higher education.

**Leveraging Purchasing Power**

States spend approximately 30 percent of their budget on health services[15]. Most of these services are provided through publicly funded programs that include Medicaid, the State Children's Health Insurance Program (SCHIP), state-funded programs for the uninsured, State Pharmaceutical Assistance Programs (SPAPs) for seniors and persons with disabilities and services provided directly through public health departments, clinics, and prisons. The combined funds spent on these programs often make the state government the largest payer of health care services in a given state.

As a major employer, states also purchase a significant amount of health care services for state employees and retirees. Often overlooked as a state lever for change, management of these benefits provide significant opportunities for states seeking to initiate innovative quality

improvement programs and payment structures—particularly since these benefits are not subject to complex federal rules such as those for the Medicaid program. Further, such programs likely have comprehensive provider networks that are paid market rates, making access and cost shifting less of a concern when realigning financial incentives among providers.[16]

States could use their purchasing power to promote systemic quality improvement by:

- Collecting quality performance data on providers and hospitals consistently throughout state-funded programs as well as the private sector—and providing results to consumers.
- Aligning payment incentives to pay for services that lead to better health outcomes; including payment for care coordination to reduce care fragmentation—and increased reimbursement for or selective contracting with high performing providers.
- Providing payment for services of non-physician providers in non-acute care settings.
- Setting consistent care standards and care management techniques across public programs—including Medicaid, SCHIP, and state employee/retiree health benefits programs—such as disease management protocols.
- Providing public investment in health information and communication technology by funding platforms for data exchange or enhanced reimbursement for providers that use electronic medical records.

**State Case Studies**

Several states have implemented or developed models for sustained quality improvement that cross public and private health systems. Leveraging their power as communicators, conveners, regulators, and purchasers, states are demonstrating their unique ability to achieve improved health care quality throughout the health system.

***Minnesota***

The state of Minnesota has established a unique collaborative of public and private purchasers of health care that agreed to set uniform performance standards, reporting requirements for cost and quality, and technology demands for health plans and health care providers. The Alliance seeks to produce widespread system change through a common strategy to "buy for quality."

The Smart-Buy Alliance purchases health care for 70 percent of state residents, including:

- The Department of Human Services, which provides health care services through Medicaid, the State Children's Health Insurance Program (SCHIP), and state-only funded health care programs;
- The Department of Employee Relations, which purchases health care services for state employees and their dependents; and
- Groups of private sector businesses such as the Chamber of Commerce (representing employers of all sizes), the Minnesota Business Partnership (representing large employers), The Buyers Action Group, and others.

Alliance members agree to enter into contracts with health plans and providers only if they meet a set of common principles. According to the principles developed by the members, health plans must:

- Reward or require "best in class"—a certification determined by various national programs that identify levels of expertise that providers of individual specialties should demonstrate.

- Adopt and utilize uniform quality measures, which will ultimately be used to make purchasing decisions. Alliance members will use a common purchase order that compares health plans according to reported quality measures.
- Empower consumers with easy access to health care information through public quality reporting including provider quality measures for MinnesotaCare providers (Minnesota's Medicaid program); consumer online surveys about care experiences according to specific conditions and procedures; a clearinghouse of cost and quality information regarding a wide range of health care provided in the state; and hospital errors as reported under the Adverse Health Events Reporting Law, which publishes a list of such events as well as recommendations for quality improvement by facility.
- Support development and/or require use of health information technology, including requiring that health plans use standardized, electronic insurance claim forms used by Medicare.

The Alliance was announced by Governor Pawlenty's Health Cabinet—comprised of administration officials as well as representatives from business and labor groups—in November 2005. Most contracts that incorporate Alliance principles will begin in 2006.[17]

***North Carolina***

The North Carolina Department of Health and Human Resources is building upon Carolina Access, its Primary Care Case Management (PCCM) program, to create Community Care on North Carolina (CCNC), a state and local partnership responsible for managing the Medicaid population. CCNC, sometimes known as the Access II and Access III programs, is a system of community health networks, organized and operated by local doctors, hospitals, health departments, and departments of social services. These networks share accountability for delivering high-quality, cost-effective care. In exchange, the state provides technical assistance, provider education, standardized tools to support best practices, and funding to support local networks.

State program staff includes physicians that work collectively to establish clinical best practices; nurses to train local networks in consistent care and disease management strategies; and statisticians and information technology experts to focus on system design, technology, and tracking and measurement issues. Each practice participating in the PCCM program receives $2.50 per member per month in case-management fees. Access II and III networks have created nonprofit administrative entities that receive an additional case-management fee of $2.50 per member per month to support the system infrastructure (ie., salaries for a medical director and case managers, rent for office space).

Since 1998, partners in 10 local networks covering 15 counties have been working together to improve quality, contain costs, and improve care coordination for 235,000 Medicaid recipients. The program has since expanded to 14 networks covering 95 counties with approximately 680,000 enrollees. Each CCNC network assesses patient utilization and risk data to identify high-risk and high-cost patients, channels those patients into appropriate disease management and case-management strategies, tracks patient and provider outcomes, and uses data to continuously improve provider practices.

A key element of the success of this model is that physicians drive the clinical-improvement process through a statewide clinical leadership group, and they develop the programs that operate in local sites. Local sites can develop their own care-improvement programs and work on system wide efforts, as they are doing with asthma and diabetes disease management. In the case of asthma DM, each practice has agreed to follow the National Institutes of Health (NIH) asthma

guidelines and has identified an internal champion to lead their clinical-improvement effort. The state hired asthma specialists to educate providers about evidence-based best practices and provides standardized support tools, such as asthma action plans. Local case managers also work with asthma specialists, physicians, and staff to help in outreach, patient education, provider education, monitoring, and evaluation.

An initial evaluation of the asthma program showed that Access program enrollees under age 21 had a 34 percent lower hospital admission rate in 2001 than the control group and an 8 percent lower emergency department rate. Even with higher pharmacy costs, due to increased awareness of the effectiveness of anti-inflammatory drugs, the average episode cost for children enrolled in CCNC was 24 percent lower than for those not enrolled in the program (down from $853 to $687 per episode of care).

Recent and planned CCNC quality improvement initiatives include managing pharmacy benefits according to clinical outcomes and cost-effectiveness; improving clinical performance in asthma and diabetes; implementing new initiatives for high-risk obstetrics patients and for patients with congestive heart failure and multiple chronic conditions; and by working with Medicaid patients to strengthen primary care physician relationships to mitigate unnecessary use of emergency rooms. Importantly, the CCNC model also creates the ongoing capacity for the state to address multiple care-improvement strategies as sites work together on continuous improvement in a range of issues.

***Pennsylvania***

Pennsylvania's Medical Care Availability and Reduction of Error (MCARE) Act of 2002 (Act 13) established the Patient Safety Authority with the goal of reducing and eliminating medical errors by identifying problems and implementing solutions that promote patient safety. To this end, the Authority promulgates new reporting requirements for hospitals, Ambulatory Surgical Facilities (ASF's) and Birth Centers—and analyses reported events to look for opportunities to intervene with facilitates improve the safety of patient care.

The Patient Safety Authority is a non-regulatory, separate entity that is governed by an 11 member board appointed by the Governor and the General Assembly. The board consists of a Physician General (Board Chair); a Physician (member); a Nurse; a Pharmacist; a Hospital Employee; a non-health care worker; and four other state residents.

Pennsylvania's Authority breaks medical errors down into three categories:

- **Incident** ("near miss")—an event that could have injured a patient. "Incidents" are reported only to the Patient Safety Authority.
- **Serious Event** ("adverse event")—an event resulting in patient harm. "Serious Events" must be reported both the Patient Safety Authority and to the Department of Health.
- **Infrastructure Failure**—an event related physical plant, facility systems, and criminal activity. "Infrastructure Failures" are reported only to the Department of health.

Reporting to the Pennsylvania Patient Safety Reporting System (PA-PSRS) is mandatory—however, no individual identifying data is included, and the system contains a number of confidentiality provisions. Reports include answers to 21 core questions, including:

- Patient Age;
- Location of Event;
- Event Type;
- Level of Harm, Contributing Factors, and Root Causes; and

- Recommendation to prevent Future Occurrence.

In preparation for the statewide rollout of mandatory reporting in June 2004, the Authority conducted a series of all-day training sessions around Pennsylvania. Nearly three-quarters of all facilities subject to Act 13 reporting requirements, and almost 90 percent of all hospitals, participated in these voluntary training programs. In addition, staff from the Department of Health participated in each training session to provide guidance and answer questions about their regulatory responsibilities.[18]

During the second half of the year, the Authority introduced mandatory reporting in three phases, each based on a specific geographic region of the state. Phase-in was over a three week period, and as of June 28, 2004, all hospitals, birthing centers and ambulatory surgical facilities were required to submit reports through the PA-PSRS system, making Pennsylvania the first state in the nation to require the reporting of both actual adverse events and near-misses. By the end of July 2004, one month after the start of mandatory reporting, almost 10,000 reports of Serious Events and Incidents had been submitted through PA-PSRS. Staff concluded that PA-PSRS was working effectively and that Pennsylvania's healthcare institutions had embraced the concept of mandatory state-based reporting. [19]

Staff attributes this level of compliance to the confidential nature of Act 13 requirements and the utility of the PA-PSRS system itself. Staff also attributed facility compliance to the comprehensive instruction provided during the 19 training sessions held around the state. This was corroborated by the results of two user surveys, one conducted at the conclusion of each training session and the other conducted in November 2004, five months after statewide mandatory reporting was implemented. [20]

Incoming reports are triaged and analyzed by a patient safety review committee. Analysis tools include event distribution and event details by location. The analysis can result in three potential outputs. First, the collected data contributes to the Authority's Annual Report published on the Website. Second, data could result in a public advisory and/or recommendation. Third, data could spur contact by the Authority with individual facilities to discuss continuous improvement strategies.

Some public advisory topics include:

- Dangerous abbreviations used in surgery
- Falls associated with wheelchairs
- Use of X-Rays to determine incorrect needle counts
- Preventing wrong-site surgery

The Authority is authorized to collect up to $5 million annually which is generated by assessments of $105 per unit in a hospital, Ambulatory Surgical Facility (ASF), or Birth Center, based on:

- Hospital—Licensed Hospital Beds
- ASF—Licensed Operating Rooms
- Birth Centers—Licensed Birthing Rooms

In 2003 and 2005, the Authority assessed $2.5 million—or half of its authorized amount.

***Vermont***[21]

Vermont embarked on a collaborative approach to setting a common vision for health and health care for people with lifelong illness in the state. More than half of all Vermont adults have a chronic illness. The Vermont Blueprint for Health includes a partnership that represents health care providers, businesses, consumers, health plans, community and non-profit groups, and government including over 80 members serving on sub committees and working groups. The Blueprint partners have agreed on an approach to refocus the state's health system from reactive to proactive—based around the needs of patients.

According to the new vision, Vermont will have a comprehensive, proactive system of care that improves the quality of life for people with or at risk for chronic conditions. The Blueprint states that the stakeholders will:

- Utilize the Chronic Care Model as the framework for the required system change;
- Utilize a public-private partnership to facilitate and assure sustainability of the new system of care; and
- Coordinate with other statewide initiatives to assure alignment of health care reform efforts.

The Blueprint established four key areas for system change. These include:

- **Patient Self-Management**: Vermonters with chronic conditions will be effective managers of their own health.
- **Provider Practice Change**: The proportion of individuals receiving care consistent with evidence-based standards will increase.
- **Community Development**: Vermonters will live in communities that support healthy lifestyles, and have the ability to present and manage chronic conditions.
- **Information System Development**: A chronic care information system (or registry) will be available to providers and will support chronic disease prevention, treatment, and management for effective individual population based care.

Vermont is piloting Blueprint components in communities in the Southwester and Northeastern portions of the State in two hospitals and health systems. Individual communities and provider practices outside of those regions will be invited to participate in some aspects of the Blueprint's pilot. Pilots will target towns served by the Northeast Vermont Regional Hospital as well as Southwestern Vermont Health Care. Target communities will have access to:

- The Vermont Community Diabetes Collaborative, including training and support for office practice redesign and clinical information system redesign;
- Self-care Management Program, including training and stipends for group leaders and course materials for participants; and
- Mini-grants for physical activity resources.

Based upon the lessons learned from the initial role out, the State will expand the Blueprint model across Vermont's entire health system.

**Conclusion**

Governors and states possess unique abilities for systemic health care quality improvement. As visionary leaders, conveners of key stakeholders, regulators of providers and insurers, and purchasers of health care services, state leaders demonstrate their profound capacity for aligning strategies and incentives for quality improvement. Early state success with comprehensive

quality improvement initiatives could provide the roadmap to rebalance the quality, access, and cost equation for American health care.

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