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INTEGRATING QUALITY INTO UTAH'S HEALTH SYSTEM REFORMS

Health reform is not about getting *more* health care; it is about making sure that everyone has access to the *right* health care, at the *right* time, *every time*. To make that happen, we have to pay attention to *quality of care*. Utah has joined the long list of states considering broad health system reforms. If Utah hopes to stem the tide of escalating costs, quality improvement must be a top priority. Utah's ranking on quality varies, from *strong*, according to the Agency for Health Care Research and Quality (AHRQ, 2006) to *very low* (48th) by a recent Commonwealth Fund report. The different results relate primarily to the specific measures emphasized. However, the majority of reports rank Utah fairly high in quality when compared to other states. Still, no matter what measures are used or where Utah ranks, there is tremendous room for improvement. Here in Utah alone, by conservative estimates, hundreds of people die unnecessarily each year due to the failures and limitations of our health care system. By building on local expertise and previous successes, Utah can bridge the state's 'quality chasm,' improve health outcomes, and achieve our goals for financially sustainable health system reforms.

This guide to quality in state health system reform includes the following sections.

1. The Problem: Why Health Reforms Should Focus on Quality

Health care spending is out of control, and this is why Utah policymakers and business leaders are finally ready to consider broad health system reforms. The U.S. spends more by far on health care than any other industrialized country (health spending consumes 16% of the GDP in 2005)—yet it ranks 37th in overall health. In its 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine concluded that "between the health care we have and the care we could have lies not just a gap, but a chasm." By

measures like those from the Commonwealth Fund, the U.S. ranks lowest among all industrialized countries in terms of *quality* of care (Davis).

Overall Ranking

Country Rankings
1.0-2.66
2.67-4.33
4.34-6.0

	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
OVERALL RANKING (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy, and Productive Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

*2003 data
Source: Calculated by Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

According to the Institute of Medicine, 44,000 to 98,000 people die in hospitals each year due to preventable injuries. The lower estimate (which was based on published research conducted in Utah & Colorado) establishes preventable injuries in hospitals as at least the 8th leading cause of death in the U.S. In fact, these hospital-related injuries are believed to cause more deaths per year than automobile accidents (43,458), breast cancer (42,297), or AIDS (16,516).

However, poor quality health care in the United States, or in Utah, is *not* caused by spending too little. In fact, states with the *highest* per beneficiary Medicare spending tend to be the states with the *lowest* overall quality ranking. How could this be? Researchers have documented what common sense could have foretold: the negative relationship between spending and quality may be driven by the use of intensive, costly care that crowds out the use of more effective care (Baicker, 2004). In other words, American medical care systems often fail to do those things that have proven value and, conversely, often do things that are *not* useful. Care delivery in America is also compartmentalized and disjointed. Effective information sharing and process coordination and basic continuity of care are rarely evident as patients move from one provider to the next, especially across institutions or settings of care. Quality improvement efforts are also often short-sighted, uncoordinated, and sometimes self-limiting due to the lack of continuity in the system. As a result of all of these design failures, American health care "gets it right" only about 55% of the time.

How does Utah measure up? According to one ranking of states by the Commonwealth Fund (CMWF), about average on overall health system performance (24th), but surprisingly in the bottom tier (48th) on standard measures of quality. However, the Agency for Health Resources and Quality ranks Utah among states with strong performance in health care quality. No matter what measure is used, all states can do better. Quality improvement must become a shared objective for all of us.

For all its limitations, the CMWF is helpful in identifying areas in need of improvement in Utah's health care delivery systems (*Utah's rank shown in parenthesis*):

- Percent of adults age 50+ who receive recommended screenings (35);
- preventive care for diabetes (*31*);
- Well child visits (*42*);
- Percent of surgical patients who receive appropriate timing of antibiotics (*45*);
- Percent of adults with a usual source of care (*46*);
- Percent of Medicare patients whose provider listens, explains, shows respect, and spends enough time with them (*50*).

Source: Commonwealth Fund Scorecard on Health System Performance, 2007

In addition to producing inconsistency in care delivery and missed opportunities, common health care system design flaws lead to failures in patient safety. A study conducted by the Utah Department of Health (and other organizations) found that in 2001, 18 adverse events occurred for every 100 hospital admissions and an estimated 407 *iatrogenic* adverse events (deaths or permanent injury caused by medical care) occurred that year in hospitals. Fatal iatrogenic medical injuries could be the *4th-* to 7th leading cause of death in Utah (Xu, 2003).

Data on rates of iatrogenic injuries in other settings of care are currently lacking; however, it is very likely that the rates are similar or perhaps even higher. Like other self-reporting systems, Utah's mandatory *sentinel event* (a serious injury or fatality caused by the care delivery process) reporting system for hospitals and ambulatory surgery centers underestimates predicted sentinel health care-related events in Utah by an order of magnitude.[1] Failure to recognize errors when they occur, failure to associate errors with injuries, lack of understanding of the reporting requirements, and fear of punishment are all possible causes for this underreporting. It is clear that before we can sustain fundamental improvements in patient safety, we must become more consistent in measuring patient safety performance in Utah's hospitals.

Taken together, medical errors, missed opportunities for providing valuable care, and the provision of services without known value produce widespread quality-associated waste. Several research estimates assert that this quality waste represents from one third to one half of our nation's expenditures on health care. Truly, quality impacts cost in health care, and cost limits our opportunity to extend access to all Americans. Health system reform thus begins—and necessarily never ends—with quality improvement.

2. Quality Initiatives within Other State Health System Reforms

Almost all current state health system reform initiatives include an emphasis on quality improvement and measurement. The growing interest in quality is motivated by the desire to obtain the best value for the state's and employers' investment and by the recognition that so much current health care spending is for care that has no measurable clinical benefit. Thus robust state quality initiatives generally recognize that the best way to contain costs is to improve outcomes.

[1] Thirty-four sentinel events were reported to the Utah Department of Health in 2002, compared with 407 events found through active investigation the year before. See www.health.utah.gov/psi.

Strategies to improve quality of care generally fall into two related categories.

1. Alignment of treatment and financing decisions with evidence-based medicine:

   - *Evidence-Based Practice Centers (EPCs) or Commissions.* Comprised of medical experts, EPCs review the scientific literature on assigned or prioritized topics or conditions and produce reports, technology assessments, and treatment protocols. Some provide technical assistance to providers.

   - *Pay for Performance or Value-Based or Quality-Based Purchasing.* These often take the form of incentives for providers (like higher reimbursement rates or reputational incentives) to offer care in accordance with established clinical standards. Evidence shows that such approaches can work, although debates continue over strategy selection (AHRQ, 2004). More sophisticated forms of value-based purchasing include bundled payments for episodes of care, redesigning benefit structures to encourage consumers to use higher quality providers, and redesigning payment systems to promote alignment with quality goals.

   - *Information Technology and Electronic Medical Data Exchange:* These activities work to eliminate duplicative care, reduce medical errors, and increase efficiency by automating key steps in complex processes that fail when left to human memory. By facilitating rapid exchange of comprehensive medical data (like medical records), providers are better able to manage treatment of chronic diseases. Good information technology (IT) also provides ready access to a wealth of data gleaned from up-to-the-minute clinical science, thus reducing variations in practice.

2. Improved patient care with an emphasis on prevention, wellness, and cultural sensitivity

   - *Prevention and Wellness Benefits and Incentives and disease or care management.*
     - Assignment to primary care provider (*medical home*). A *medical home* replaces sporadic, crisis-driven care with regular, pro-active, patient-centered care which is more cost effective over the long-term.
     - Smoking cessation and weight loss programs.
     - Encouraging preventive care by eliminating or minimizing co-pays.

   - *Culturally and Linguistically Appropriate Services (CLAS):* Racial and ethnic disparities in care are well documented. Some disparities are related to socioeconomic factors like access to affordable coverage—but not all. Effective communication between providers and patients is therefore critical to addressing disparities.

The following table illustrates the use of these approaches by selected states.

State	Evidence-Based Medicine	Pay for Performance (P4P) or Value-Based Purchasing	Prevention, , care management, electronic medical records
CA	Integrated Healthcare Association is a statewide leadership group that promotes quality improvement, accountability, and affordability of health care. http://www.iha.org/. Efforts include: Quality measurement, uniform interoperability standards, health information technology (HIT)		Rewards for healthy behaviors for Medicaid, state employee plan, Healthy Families (CHIP). Medical homes for children.
LA	Health Care Redesign Collaborative created after Hurricane Katrina to rebuild health care system to emphasize quality and evidence-based standards,	To participate in medical home network, physicians must report on quality measures. Uses a 'medical home' model: Everyone is assigned a primary care provider who coordinates care.	

	and electronic data exchange. Overseen by LA Health Quality Forum. http://www.dhh.louisiana.gov/offices/?ID=288		
MA*	Health reforms establish Health Care Cost & Quality Council. Goals: 1) Reduce cost of care by avoiding preventable hospitalization & errors; 2) Ensure safety & effectiveness of care; 3) Improve screening for and management of chronic illnesses; 4) develop & implement useful measurements of quality; 5) reduce health disparities; 6) promote quality improvement through transparency initiatives. http://www.mass.gov/?pageID=hqcchomepage&L=1&L0=Home&sid=Ihqcc.		
ME*	Part of Dirigo Health agency, Maine Quality Forum develops measures to compare healthcare quality & produces annual reports, dissemination of information to providers on best medical practices and to consumers on overall health and health care. Quality Forum makes recommendations on new technologies for the purposes of capital planning, and collaborates w/ Maine Health Data Organization on data exchange. http://www.mainequalityforum.gov/		Efforts now underway to improve case management as a cost containment strategy.
MI	Connector-based plan w/ basic benefit package emphasizing preventive care. http://www.mqic.org/ Michigan's sophisticated Quality Improvement Collaborative appears to be unconnected to the broader reforms, however.		Healthy lifestyle initiatives will be built into Connector-based reform to contain costs.
MN*	Q-Care initially sets standards for care in four high-cost areas: diabetes, hospital stays, preventive care for adults & kids, cardiac care. *Cost savings estimate: $153 million* New Gov's 'Healthy Connections' plan increases transparency to enable informed choices. http://www.health.state.mn.us/healthinfo/qcare.html	QCare (Quality Care & Rewarding Excellence) rewards top-performing providers.	
MO	Missouri's system redesign includes strengthening information technology (IT), starting with Medicaid.		Medicaid redesign (HealthNet) focuses on prevention & wellness: All enrollees will be assigned to medical homes & assessed for care needs. http://www.familiesusa.org/assets/pdfs/missouri-blunt-force.PDF
NC	Standards for care in Medicaid & state employee health plan decided by advisory group. Protocols to be shared with private market.		Medicaid Community Care Initiative implements quality standards and 'medical homes' for Medicaid managed care plans. Savings estimated at $154-170 million for FY 2006. http://www.communitycarenc.com/
OR*	*Road Map for Health Care Reform* (7-07) proposes to address quality, cost, and access; brings all care into alignment with evidence-based medicine through independent quality institute. http://www.oregon.gov/DAS/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf		Plan will establish primary care home for every Oregonian.
PA	Improves patient safety by eliminating hospital-acquired infections & medical errors. Health Care Cost Containment Council uses evidence-based resources like U.S. Preventive Services Task Force to conduct mandate benefit reviews. http://www.ohcr.state.pa.us/prescription-for-pennsylvania/PlainEnglishLegislation.pdf	Pay for Performance (P4P) to reward quality care.	Disease management for chronic conditions; improved access to preventive care by increasing supply of primary providers. Implements statewide smoking ban.
RI	*Wellness Health Benefit Plan*: Consumers commit to improve health by selecting a primary care provider and participating in wellness programs involving, for example, weight control and smoking cessation. http://www.commonwealthfund.org/usr_doc/silow-carroll_ritecare_598.pdf?section=4039		
VT*	"Catamount" plan is basic benefit package for all uninsured. http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=471168		Controls cost of illness through reimbursement for phone consults, premium discounts for enrolling in health promotion & prevention programs & reduced cost-sharing for chronic illness management
WA*	May '07 legislation created the Washington Quality Forum (WFQ) to address disparities and expand chronic care management. Statewide Technology Assessment Program uses scientific evidence to guide coverage decisions.	WQF implements P4P	WQF uses an informed patient decision model that encourages prevention and establishes medical homes for children.

More time and experience is needed to know the merits or drawbacks of these and other diverse approaches. However, given the specific challenges that Utah faces in improving health care quality and controlling costs, key "states to watch" include the following (*marked in the table above with asterisks*):

MA, ME, OR, VT, WA: These states' initiatives are robust and well integrated into broader systemic health reforms. They also go "the extra mile" in an effort to ensure that quality becomes integral to every phase of health care delivery.

MN: Minnesota's quality efforts are directly linked to cost containment priorities, which makes them particularly instructive for penny-pinching states (like Utah) that frown upon increases in government spending. It also bears noting that the United Health Foundation has ranked Minnesota—yet again—as the healthiest state in the nation. Minnesota has been ranked #1 or #2 every single year since 1990. For the final feather in its cap, Minnesota has consistently had the lowest uninsured rate in the nation (United Health Foundation, 2007).

How can we draw together the collective wisdom of these different state initiatives to craft a systematic, multi-year plan for quality improvement that meets Utah's distinct needs? The first step is to draw on our own local expertise, as outlined below.

3. Integrating Quality into Utah's Health Reforms: Recommendations

Quality maximizes value, and quality contains costs. These are the fundamental principles motivating the diverse quality-based reforms we propose. Utah policymakers and business leaders are already convinced of the importance of maximizing value and containing cost in health care systems, but they need more systematic integration of *quality improvement* into proposals for health system reforms (United Way of Salt Lake, 2007).

Over the years Utah has pursued many different quality and patient safety initiatives, with varying results. Recent efforts have included:

- Working together, the state and key providers developed and implemented a sentinel event reporting system for hospitals and ambulatory surgery centers.
- Utah also implemented a state rule that requires all hospitals to have active programs in place to prevent adverse drug events (ADEs) and audits these programs every three years.
- Working with the Centers for Medicare and Medicaid Services (CMS), a division of the Federal Department of Health and Human Services, Utah has implemented a demonstration project aimed at encouraging adult primary care doctors to use electronic medical records (EMRs) to better manage chronic disease and preventive services. Under this program, physicians receive substantial financial incentives to adopt and use EMRs in their practices and to show improvement on standard evidence-based quality measures.
- Utah recently initiated a series of transparency efforts to report data comparing quality and cost across different hospital facilities, using two web-based tools, UT CheckPoint (using the CMS core measure set) and UT PricePoint.
- The state has recently begun a parallel effort to provide more data about hospital level performance, using an all-payer hospital database and selected measures from the AHRQ Quality and Patient Safety Indicator set. This initiative was encouraged by state legislation.

Though worthy, these last two transparency initiatives illustrate the limitations of Utah's current statewide quality programs. The basic idea behind consumer-oriented transparency is that patients and their families could use these tools to shop for value for their health care dollar, and facilities would in turn increasingly compete for these dollars by providing better value. While this kind of transparency inherently adds some value because it can help to keep more of hospital leaders' attention and resources focused on quality and consistency, these tools alone are unlikely to change patient choices in the current system. In fact, health care systems are inherently at odds with the basic assumptions that drive consumerism in other markets. First, consumers do not have much control over where they get care. Nor do they have enough medical knowledge or access to sufficient information to make choices about what constitutes a "better value" for different health care needs.

Furthermore, research shows that consumers do not turn to "objective ratings" for guidance in their health care decisions in today's market. A recent study by the Harvard School of Public Health and Robert Wood Johnson Foundation found that individuals are more likely to base health care decisions on the advice of family and friends than on expert ratings (Robert Wood Johnson Foundation, 2007). Finally, thus far transparency efforts in Utah have been isolated mostly to hospital care; they have yet to provide any information about physician performance or to encourage better coordination and collaboration across settings of health care delivery.

These transparency efforts are well-intentioned and represent a good start. But they fall well short of their goal, because they are not fully integrated and do not acknowledge the current environment or address fully the limitations of the system. Instead of just limited, uncoordinated efforts, we need bold, systematic, programmatic initiatives for quality improvement. The following recommendations would place Utah at the forefront of statewide quality improvement:

1. **Create a Health Benefits Commission to establish and continuously maintain an essential benefit package for all Utahns.**

As proposed in the United Way Financial Stability Council's conceptual framework for health reform in Utah, the Health Benefit Commission would have both rule-making and adjudicatory functions. Members of the Commission would be appointed by the Governor submitted to the Utah Senate for final approval. Commissioners would be responsible for initially identifying and then continually updating the list of medical services included in the basic benefit package. Since their determinations would be based upon clinical effectiveness, the Commission must be supported in their efforts by a public-and private partnership of medical scientists which would serve as the primary resource for establishing evidence-based standards of care and guidelines for the essential benefit package. This critical partnership between a strong, state-mandated Commission and evidence-driven medical expertise will enable Utah to address the massive quality-related waste embedded in the current insurance and health care delivery systems in our state.

Further duties of the clinical science partnership with the Health Benefit Commission could include:

- Centralized collection of quality information across the state, emphasizing episodes of care.
- Support for and facilitation of collaboration among quality efforts statewide;
- Helping providers to collect and use data for improvement;
- Disseminating quality data in transparent formats that are useful to a broad range of audiences.

Utah may not need to create new structures and institutions to perform these important tasks; what *is* needed, however, is a thoughtful, strategic integration of quality improvement efforts into the proposed health system reform framework. The proposed Health Benefit Commission would build upon the nationally recognized quality improvement leadership of Intermountain Healthcare, HealthInsight, and others already present in our state. It would be the task of the Health Benefit Commission to coordinate with and magnify the effectiveness of these groups already working together on transparency of cost and quality data and on financial incentives for quality through the Utah Partnership for Value-Driven Health Care (UPV). The UPV is the state's applicant for AHRQ Chartered Value Exchange (CVE) status. This effort already incorporates the work of HealthInsight, the Utah Health Data Committee, Utah Medicaid and key insurers, the Salt Lake Chamber of Commerce and key business interests, the Utah Medical Association, the Utah Hospital and Health Systems Association and their websites mentioned above, and the Utah Health Information Network, among others.

The AHRQ currently sponsors and supports similar community efforts around the country and serves as a clearinghouse for best practices through the CVE program. Utah could potentially join the Robert Wood Johnson Foundation's Network for Regional Healthcare Improvement to learn from and contribute to the six existing, more mature regional coalitions for health care improvement (NRHI, 2006). The Utah partners listed above should also consider formal affiliation with one of the *Aligning Forces* sites also sponsored by the Robert Wood Johnson Foundation. The purpose of the *Aligning Forces for Quality: The Regional Market Project* is to help communities across the country improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression and heart disease.

Among the various options for initial action available to the Health Benefit Commission, we would recommend attention to the following:

- **Strengthen the statewide mandatory public health surveillance system for preventable hospital deaths and impairment** (Utah Department of Health, 2003). A preventable hospital death due to medical error is a sentinel event indicating immediate need for substantive change in patient care. Just as public investigations of commercial airline crashes have exposed systemic, correctable problems in the air traffic system, timely investigation of preventable medical errors is necessary to assure patients that systemic problems in health care delivery are being addressed and eliminated. However, self-reporting systems alone have limited utility and will never provide an accurate picture of performance or improvement over time. As an initial investment in more active surveillance, Utah's surveillance system for preventable injuries in hospitals should be expanded to include a random, trigger-based chart review of patient care in all Utah hospitals. We cannot improve what we cannot measure effectively.

- **Require basic, ongoing quality improvement training for the medical staff and employees of Utah hospitals, clinics, nursing homes, and home health agencies.** Provider quality improvement programs must be assessed regularly against recognized clinical standards, and the results of these assessments should be reported to the public. Quality improvement cannot be achieved simply by administrative fiat. It requires the continuous, coordinated, committed efforts by leaders and by all individuals with front-line health-care responsibilities. Every health care worker should understand the fundamental importance of quality improvement and be empowered with the knowledge and skills to contribute to it.

- **Establish mandatory shared-decision making processes for patient care as the method for informed consent before medical intervention.** Improving quality means providing *no less* cared than the patient needs, but also *no more* care than the patient wants. Patients are often more risk averse than are physicians, yet may not speak up about their concerns. Studies have shown that, if given good information about the likely consequences of each possible option, the average patient would choose recommended surgical interventions 40% less often than their provider. Shared decision tools can help to align treatment goals and patient wishes. These tools are already available for use in clinical settings, but must be systematically incorporated into health system processes.

2. **Establish 'medical homes' within the context of proposed health system reforms, starting with Medicaid and CHIP; develop a medical home plan for the state.**

A *medical home* is defined by the American Academy of Pediatrics and the American Academy of Family Practice as an approach to health care characterized by a partnership between patients and their care providers. A medical home is the point of first contact between a family and the health care system that is always accessible, with continuous service over the long term, and where primary care is comprehensive, family-centered, coordinated, compassionate, and culturally effective (American Academy of Pediatrics, 2002). The proposed "Essential Benefit Package" should support full access for all to a medical home so that Utah's families receive the care they need at the appropriate time and place, avoiding overuse of emergency rooms.

There may be some upfront cost associated with implementing 'medical home' access in states like Utah where there is a critical shortage of primary care providers. But the initial expense will undoubtedly pay off later. States with more family practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality of care (Baicker, 2004). Patients with a medical home are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. Thus better coordination and continuity of medical homes will improve outcomes *and* cut costs over the long term.

As the concept is defined by the national primary care specialty societies and leading business interests, medical homes can be a demanding undertaking. To maximize value from health system change, Utah should invest the necessary resources to prepare physicians to meet the exacting requirements of the medical home concept.

3. **Expand IT (Information Technology) capacity among all providers.**

In a 2003 survey of physicians, the Commonwealth Fund found that at the time of a patient's appointment, his or her medical records, tests results, and other related information were unavailable 72% of the time (AHRQ, 2007). HealthInsight estimates that 30-45% of Utah physicians currently use electronic medical records (Donnelly, 2007). While this level of use is high when compared to other states, we have yet to reach the tipping point in EMR use that will drive system-wide change. There is a wealth of data available just waiting to be used for quality improvement. Information technology can help us tap that resource. Improved IT can also serve as a powerful tool to help clinicians put evidence-based standards and up-to-the-minute scientific advances into immediate practice, improving quality and efficiency. The state should expand upon current efforts

to support adoption and use of EMRs by physicians and institutions. We should also support efforts to create effective clinical Health Information Exchange (HIE) among providers across settings and along the full continuum of care.

4. **Develop statewide CLAS (Culturally and Linguistically Appropriate Services) standards and implement them through public-private partnerships**.

Cultural competence has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professions and enables that system, agency or those professions to work effectively in cross-cultural situations (Cross, 1989)." Recognizing the need for a national consensus on cultural and linguistic standards for health care, the Federal Office of Minority Health released a set of standards for culturally and linguistically appropriate services (CLAS) in 2001. The CLAS standards are designed to address health disparities by correcting inequities in health care delivery systems and ensuring that services are responsive to the needs of all consumers. The standards are organized under three categories:

- Culturally competent care;
- Language access services;
- Organizational supports for cultural competence.

In historically homogeneous cultures like Utah the need for CLAS standards may be magnified. This somewhat counter-intuitive observation is based on the following related considerations:

- With a few notable exceptions, health care delivery systems have been designed to serve the state's historically homogenous populations.

- The relative lack of critical mass has made it difficult for Utah's ethnic communities to command the "market share" that might otherwise stimulate culturally and linguistically appropriate service delivery.

As the most ethnically diverse state in the nation, California has extensive experience using statewide cultural competency standards for its health plans. Following are take-home messages from the California context to states considering statewide standards:

- **Dedicate staff to cultural competence.** Plans that tried to add cultural competence activities to other staff responsibilities eventually recognized the need for at least a full-time cultural competence coordinator.

- **Link cultural competence to quality improvement.** Cultural competence activities pursued in connection with quality improvement efforts were more likely to be integrated into health plans' operations.

- **Improve capacity to track racial, ethnic, and language data.** Plans were unable to achieve statewide standards without collection of member-specific data.

- **Collaborate and get assistance where possible.** Many tasks, such as translating documents, were complicated and resource-intensive. Cross-plan collaborations were found to be extremely helpful (Brach, 2006).

4. Conclusion

At the heart of Utah's health care crisis lies a paradox: total spending is out of control, yet 17.4% of the population is uninsured. Premium increases run triple the rate of inflation, yet quality of care is not keeping pace with the growing complexity of health care delivery systems. Health system reform is an inherently complex undertaking in that it must simultaneously address access, cost, and quality in order to be successful. Such a process takes time and patience on the part of all stakeholders—policymakers in particular. In Utah certain quality initiatives, such as the medical home concept, transparency initiatives, or the adoption and effective use of electronic medical records, will call for an upfront investment. However, based on the available research and other states' experience, such investments will pay off in the long run, in the form of significant savings and improved health outcomes for all.

5. Quality-Related Resources and Links in Utah

HealthInsight offers free or reduced cost consulting to physicians and other provider institutions across the state to improve quality. It is the federally designated Quality Improvement Organization or QIO for Utah. HealthInsight also compiles and publishes composite rankings on hospital, nursing home, and home health performance. www.healthinsight.org

MyHealthCare in Utah is designed to help consumers make informed decisions about their medical care. health.utah.gov/myhealthcare/

Utah Checkpoint is a collaborative effort of the Utah Hospital and Health Systems Association, the Utah Department of Health, and HealthInsight. http://www.utcheckpoint.org.

6. National Quality-Related Resources and Links

Agency for Health Care Research and Quality http://www.ahcpr.gov/

Institute for Clinical Systems Improvement –http://www.icsi.org (evidence based guidelines for care)

National Guideline Clearinghouse – http://www.guideline.gov (evidence based guidelines for care)

Centers for Medicare and Medicaid Services provides information on many hospitals in the United States. A consumer friendly site is under development. http://www.cms.hhs.gov/quality/hospital/

Hospital Compare - A quality comparison tool for adults, including Medicare beneficiaries. http://www.hospitalcompare.hhs.gov

Joint Commission on Accreditation of Healthcare Organizations -- http://www.jointcommission.org/

National Institutes of Health – http://www.nih.gov

U.S. Preventive Services Task Force – http://www.ahrq.gov/clinic/uspstfix.htm

7. References and Suggestions for Further Reading

Agency for Healthcare Research and Quality (2002). *Medicaid Uses of AHRQ Research*. Fact sheet. http://ww.ahrq.org.

AHRQ (2004). *Strategies to Support Quality-Based Purchasing: a Review of the Evidence.* Pub. No. 04-P024. http://www.ahrq.org.

AHRQ (2005-1). *Quality Improvement and Performance Measurement in Medicaid Care Management*. Fact sheet. http://ww.ahrq.org.

AHRQ (2005-2). *Guide to Health Care Quality: How to Know it When you See it*. http://ww.ahrq.org.

AHRQ (2006). *Utah: What is the Overall Health Care Quality Performance Compared to all States?* http://statesnapshots.ahrq.gov/statesnapshots/statesummary.jsp?menuId=3&state=UT&level=0

AHRQ (2007). *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies.* http://www.ahrq.org.

American Academy of Pediatrics (2002). The Medical Home Policy Statement. *Pediatrics*, v. 110, No. 1.

Association of State and Territorial Health Officials (2005). State Policy Options to Establish Medical Homes for Children and Youth. Issue Report. http://www.astho.org.

Baicker, K. and A. Chandra (2004). "Medicare Spending, the Physician Workforce, and Beneficiaries' quality of care." *Health Affairs* (Millwood) Suppl. Web Exclusives: W184-97.

Center for Studying Health System Change (2005). *Can Money Buy Quality? Physician Response to Pay for Performance*. http://ww.hschange.org.

Cross, T.L. et al (1989). "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed." CASSP Technical Assistance Center, Georgetown University Child Development Center. Washington, DC.

Cylus, J. and G. F. Anderson (2007). *Multinational Comparisons of Health Systems Data, 2006*. The Commonwealth Fund.

Davis, K. et al (2007). *Mirror, Mirror on the Wall: An Update on the Quality of American Health Care through the Patient's Lens*. The Commonwealth Fund. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=482678

Donnelly, S. (2007). HealthInsight Email communication.

Huynh, P.T., C. Schoen, R. Osborn, and A. L. Holmgren (2006). *The U.S. Health Care Divide: Disparities in Primary Care Experiences by Income*. The Commonwealth Fund.

Institute of Medicine (1999). *To Err is Human: Building a Safer Health System*.

Institute of Medicine (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. http://www.iom.edu/?id=12736.

Midwest Business Group on Health with The Juran Institute and The Severyn Group (2002). Reducing the Cost of Poor-Quality Health Care through Responsible Purchasing Leadership. http://www.mbgh.org.

National Committee for Quality Assurance NCQA (2006). *Pay for Performance: A Critical Examination*. Proceedings from the NCQA 2006 Policy Conference.

NCQA (2007). *NCQA Medicaid Managed Care Toolkit.*

National Conference of State Legislatures NCSL (2004). *Evidence-Based Medicine and State Health Policy*. http://www.ncsl.org.

National Conference of State Legislatures NCSL (2007). *Medical Homes.* http://ww.ncsl.org/programs/health/medhom.htm.

Network for Regional Healthcare Improvement (2006). Regional Coalitions for Healthcare Improvement: Definitions, Lessons, and Prospects. Robert Wood Johnson Foundation.

Oregon Health Policy Commission (2007). *Roadmap for Health Care Reform: Creating a High-Value Affordable Health Care System*. Office for Oregon Health Policy and Research. http://www.oregon.gov/DAS/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf.

Robert Wood Johnson Foundation (2007). *What Do Americans Think about the Role of Quality of Care Information When Making Decisions about their Health Care?* Research Highlight.

Schoen, C. and R. Osborn, P. T. Huynh, M. Doty, J. Peugh, K. Zapert (2006). "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive. W555–571.

United Health Foundation (2007). Americas Health Rankings. http://www.unitedhealthfoundation.org/ahr2006/states/Minnesota.html

United Way of Salt Lake (2007). United Way Financial Stability Council Health Care Working Group Plan. http://uwfinancialstability.org/images/stories/healthcare-proposals.pdf

Utah Department of Health (2003). "Utah Rule Provides First Year of Patient Safety Data." *Utah Patient Safety Update* 1(2). http://health.utah.gov/psi/pubs/psup_v1n2.pdf

Voris, M. (2007). *Leading the Way: State Health Reform Initiatives*. National Governor's Association Center for Best Practices. http://www.nga.org/center.

Xu, W. (2003). "Utah Statewide Surveillance of Medical Injuries." Poster Session. http://health.utah.gov/psi/Poster/UT-Sample1Poster.pdf