

The History of The Foundation for Health Care Quality

Seattle, Washington

1988-2010

Introduction

This history tells the story of the people and partner organizations who established and have sustained the Foundation for Health Care Quality. Based mainly on interviews of former and currently involved Foundation staff and board directors as well as outside collaborating community members, this story is organized chronically by major health care movements nationally and locally in Washington State. Throughout, measures of the FHCQ's community value are pronounced. Emphasis is paid to the legislative, regulatory and social context of the times as well as key organizational success factors in describing the Foundation's inception through its current status in September 2010.

This history is dedicated to all the community members who have helped shape and carry out the vision of creating a cooperative safe table for matters relating to health care quality in Washington State.



Glossary of Terms and Definitions

AHRQ (Agency for Health Care Research and Quality), a division of the U.S. Public Health Service that researches consumer satisfaction, health outcomes and health care quality. Formerly, the Agency for Health Care Policy and Research.

BOAT (Back Pain Outcomes Assessment Team), an early Foundation project to examine back pain and clinical outcomes.

Business Groups on Health, voluntary associations of employers (usually self-insured) and others, who are interested in containing health care costs. Activities range from direct purchasing to health and wellness initiatives.

ChB, the historic Scottish degree for doctor of surgery, see Peter Dunbar.

CDC (Centers for Disease Control and Prevention), the division of the U.S. Public Health Service that takes the lead in analyzing and fighting the leading causes of death and disability .

CHARS (Comprehensive Hospital Abstract Reporting System), hospital discharge data collected and organized by the Department of Health in order to analyze health care outcomes and costs.

CHIMS (Community Health Information Management Systems initiative), a national initiative to create ways to collect accurate clinical data in a timely manner for providers and purchasers. Its mission is to share data, develop clinical measures to improve quality, reduce costs, and enable employers to purchase value.

CHIN (Community Health Information Networks), a network of organizations using information technologies and telecommunications to store, transmit, and transform clinical and financial information. This information can be shared among cooperative as well as competitive groups.

CHITA (Community Health Information Technology Assessment), a program within FHQC that analyzes and sponsors educational forums on medical information technology advances.

CLI (Clinical Laboratory Initiative), a Washington State effort to improve the quality and use of clinical laboratory testing.

CMS (Centers for Medicare and Medicaid), a department of the Health and Human Services responsible for oversight and management of the Medicare and Medicaid programs. Formerly, the Health Care Financing Administration.

COAP (Cardiac Outcomes Assessment Program), one of the first of the Foundation's programs focusing on improving cardiac care.

CQIP (Certified Quality Improvement Program), an agency within the Department of Health that certifies agencies that are protected from outside discovery under Washington statute as quality improvement programs.

DOD (Department of Defense)

DOH (Department of Health), an agency in Washington State that provides some health care services and conducts studies on the quality and availability of health care in Washington State.

Dot.com, a term coined in the late 90's referring to high technology firms which contributed to an economic bubble that burst.

DRG (Diagnostic Related Group), a prospective payment system developed by Medicare in the 1980's as a method of anticipating and controlling hospital costs by paying a flat fee based on patient diagnosis, age and severity of illness.

DSHS (Department of Social and Health Services), the agency in Washington State that manages Medicaid and other social and health programs, such as Child Protective Services and Developmental Disabilities.

EDI (Electronic Data Interchange), a term used to cover a range of data sharing, programming, electronic medical record related activities.

EHPC (Employers' Health Care Purchasing Cooperative), a purchasing pool created by the HCPA for small business owners in the hopes that pooling resources would reduce costs.

EMR (Electronic Medical record)

FACCT (Foundation for Accountability), one of the earliest non-profit organizations interested in quality care and health care outcomes. An early leader in CHIMS.

FHCQ (Foundation for Health Care Quality)

HCA (Health Care Authority), the agency in Washington State that manages the purchasing of health care for all state employees and sets standards for contracts for the provision of care.

HCPA (Health Care Purchasers' Association), a voluntary association of self-funded employers that formed to address escalating health care costs.

HealthKey, a Foundation project that focused on a creating Public Key Information (PKI) through which information could be transmitted, secured and shared.

Health Maintenance Organization Act, 1973, the law which enabled physician groups and others to work together to create managed care organizations, such as Group Health Cooperative of Puget Sound and other non-staff models. Payment was based on capitation—a flat fee per member per month.

HIPAA (Health Information Portability and Accountability Act), 1996, a law that protects patient privacy. It put tremendous pressure on health care institutions to keep patient records electronically secure and private.

JCAH (Joint Commission on Hospital Accreditation—now JCOA—Joint Committee on Accreditation)

John A. Hartford Foundation, Inc., the Foundation which supported the health care marketplace initiative, CHMIS and was a major early funder of the Health Care Purchasers' Association and the Foundation for Health Care Quality.

LeapFrog Group, a voluntary program of large self-insured employers aimed at mobilizing employer purchasing power to influence health care safety, quality and customer value.

LPGs (Laboratory Practice Guidelines), standards of clinical testing.

Life Sciences Discovery Fund, a Washington State fund created in 2005 from the Master Tobacco Settlement Agreement used to improve the health and economic wellbeing of residents.

NBGH (National Business Group on Health), a national organization of self-funded employers dedicated to research effectiveness, outcomes and health care cost control.

NGA (National Governors' Association), the association of state governors that examines issues of common concern to the states.

ODIN (Outbreak Detection Information Network), a federally funded project of FHCQ that resourced the State (Washington State Department of Health, Health Care Authority, city/county Departments of Public Health) with information to detect early outbreaks of flu, West Nile Virus, or bioterrorism.

OTA (Office of Technology Assessment), the Congressional Office of Technology Assessment closed on September 29, 1995. During its 23-year history, OTA provided Congressional members and committees with objective and authoritative analysis of the complex scientific and technical issues of the late 20th century. It examined delivery of public services in innovative and inexpensive ways, including distribution of government documents through electronic publishing.

PCI (Percutaneous Coronary Intervention), a therapeutic medical procedure used to treat narrowed coronary arteries of the heart. Studied by COAP.

PhRMA (Pharmaceutical Researchers and Manufacturers Association), one of the agencies which funded projects of the Washington Patient Safety Coalition.

PKI (Public Key Information), a safe digital portal where health care information can be securely exchanged.

PPO (Preferred Provider Organization), a payment system devised by health insurance companies whereby physicians were enticed to accept reduced per service fees with the promise of increasing or sustaining patient volumes.

PRO-West (Professional Review Organization), an association of physicians and quality experts who contract with entities such as Medicare to provide quality oversight of medical services. Now known as Qualis

PSRO (Professional Standards Review Organization), an authorized health care surveying agency which was the predecessor to PRO agencies.

Puget Sound Health Planning Agency, one of the health planning agencies authorized during the Nixon administration. This agency wrote the grant which created the Health Care Purchasers' Association.

OB COAP (Obstetrical Care Outcomes Assessment Program), a new program of the Foundation to examine the variations in obstetrical care, particularly in the intra labor time frame.

QMAS (Health Care Quality Measurement Advisory Service), the last FHCQ program area supported by the John A. Hartford Foundation as part of their marketplace initiative.

RBRVS (Resource Based Relative Value Scale), a medical services assessment tool which was designed to provide an objective basis of time, effort and complexity of service as a means of fairly establishing payment levels for those services.

Region X, one of the ten federal regions in the US that focuses on Public Health, Medicare, Medicaid and other federal health programs. Region X is comprised of Alaska, Idaho, Oregon and Washington.

SAHC (Seattle Area Hospital Council), a former separate organization of the Washington State Hospital Association that focused on the interest and concerns of Seattle hospitals.

SCOAP (Surgical Care Outcomes Assessment Project), a major program of the Foundation for Health Care Quality which tracks variations in the provision of selected surgical services in participating Washington hospitals.

SORCE (Surgical Outcomes Research Center), a center at the University of Washington's that assesses the impact of surgical procedures on patients, society, and the healthcare system.

StORQS (Statistical Obstetrics Review Quality System), one of the first research projects of the Foundation for Health Care Quality.

UR (Utilization Review), a process assessing both quality and quantity of medical services, with the goal of attaining appropriate care for patients.

WEDI (Workgroup for Electronic Data Interchange), a workgroup formed in the last year of George H.W. Bush's Presidency to create a national electronic medical records system. Its work is still on-going as an independent 501(c)3.

WSHA (Washington State Hospital Association), the state association of all of Washington hospitals.

WSMA (Washington State Medical Association), the state association of Washington physicians.

WSPRSO (Washington State Professional Standards Review Organization), a federal agency that monitors the cost and quality of health care for Title 18 (Medicare) and Title 19 (Medicaid) enrollees. It evolved into PRO-West, which then evolved into Qualis.

WPSC (Washington Patient Safety Coalition), one of the programs of the Foundation for Health Care Quality.

Y2K, a computer programming concern about the ability of computers to convert from 1999 to 2000. This caused some date-related processing to operate incorrectly for dates and times on and after January 1, 2000, and caused great programming concern

Foundation for Health Care Quality: Incubator for Quality and Excellence

Tucked away in a downtown Seattle office, the Foundation for Health Care Quality (FHCQ) has had a steady, quiet but key role in advancing quality health care locally in Washington State as well as nationally. The cornerstone for the Foundation and its programs is trust, a rare feature in health care policy discussions and reform efforts.

The Foundation has a long history of respectful clinical collaboration where physicians can work with colleagues to improve their clinical skills, reduce practice variation and improve patient outcomes thereby saving millions of dollars for the health care system as a whole. This collaborative culture permeates all the Foundation's programs.

The Foundation's history also includes concerted attempts to electronically capture and share health care information which is essential to feed the process of quality improvement. Ultimately, quality assessment is driven by accurate clinical information. Without access to clinical information and patient outcomes, the quality of health care would be virtually impossible to measure and improve. This early work with community information systems and quality measures in many ways became the bedrock for health care reform efforts in 2010 focusing on 'meaningful use.'

The Foundation's collaborative, safe-haven approach is the key to success across all programs. The diversity and direction of its programs also mirrors the zigzagged national initiatives to control health care costs and offer meaningful tools to do so. In its early years, FHCQ was a key player in a national brain trust on health care quality initiated and sustained by the John A. Hartford Foundation. A major part of the quality initiative was an attempt to build community health information networks that shared and exchanged health care data between and among health care enterprises.

With the passing of health care reform in March 2010, the Foundation's history offers valuable lessons learned. It also offers an organizational template, data, and experience that can be applied to current and future reform efforts.

"This history of the Foundation for Health Care Quality is timely evidence of how collaborative, participatory, non-adversarial peer-to-peer data gathering can improve the quality of medical care, reduce complications and re-interventions, and ultimately produce financial savings. In an era of polarized opinion concerning systemic health care reform, the Foundation has successfully negotiated the gauntlet by serving as a trusted neutral. It is a history of credible, methodical, and persistent commitment to changes that work because they truly are built upon recognized consensus rather than mandate. The Foundation's history is the story of the creation of a, 'safe table that offers a trusted environment for special projects where researchers have the independence to pursue work that would not be possible or trusted elsewhere.' It is, in short, a reliable roadmap for meaningful improvement of health care systems everywhere."

-Jeff Gingold, Board Chair,
Attorney, Lane Powell Spears Lubersky.

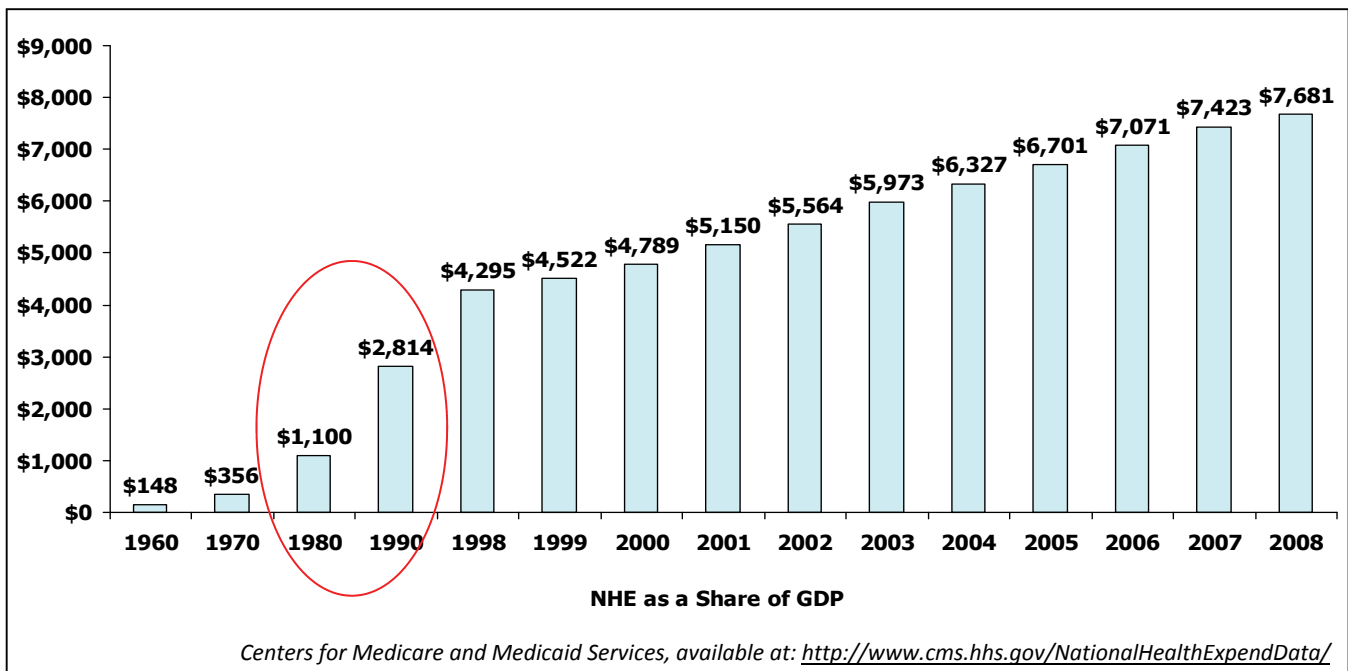
I. Zeitgeist: Search for Cost Containment Health Care Marketplace 1970s to 1990s

Changes surged through the health care industry from the 70's to the present in attempts to harness health care spending. President Richard Nixon instituted wage/price controls in the early 70's to try to get a handle on cost. He created the first PSRO (Professional Standards Review Organization) and authorized health planning agencies. He also oversaw the passage of the Health Maintenance Organization Act in 1973 which changed the ways in which the health care delivery system could be organized. In the early 80's the American Hospital Association started a voluntary effort to look at utilization review and length of hospital stay. In 1983, Medicare adopted the DRG (Diagnostic Related Group) prospective payment system for hospitals as a method of anticipating and controlling hospital costs.

The DRG payments for hospitals were followed in 1989 by changes in physician compensation with the RBRVS (Resource Based Relative Value Scale) which were designed to gradually adjust differences in compensation between specialty and primary care practices.

The Health Maintenance Organization Act led to tremendous growth of managed care in the late 80's and early 90's and shifted more financial risk to providers. These management systems caused a clamor for information from consumers, purchasers, health plans and providers. Managed care shifted the focus of the delivery system away from the cost-plus fee-for-service enterprise, rendering the counting and processing of transactions, costs, and services as inadequate for managed care information needs. The new partnerships in preferred provider organizations (PPOs) and the demand for value in health care purchasing changed the questions on how to determine cost, quality and value. Learning how to share and use information became essential for success.

Despite these myriad efforts, health care costs more than doubled between 1980 and 1990. Premiums grew from \$1,100 per employee per year in 1980 to \$2,814 by 1990. They would continue their double digit increases year after year, making employers frantic to bring these costs under control. Numerous new initiatives emerged from Utilization Review and Quality Initiatives to the formation and expansion of business groups on health across the country.



President George H.W. Bush charged his Secretary of Health and Human Services to adopt an electronic medical record (EMR) in 1991 to improve quality and lower costs. The Secretary established WEDI (Workgroup for Electronic Data Interchange) to create a national EMR, but this workgroup was unable to do so by the end of Bush's administration.

With President William Clinton's election in 1991, major national health care reform was now at the top of the new administration's agenda. The first PPOs were coming on the market. At one point in the early 1990's there were over 20 PPOs in Seattle alone, far too many for a market of one million people. The basic premise of a PPO is that a preferred provider is willing to accept discounted payments in exchange for increased patient flow—but not knowing which one of these new organizations would survive, physicians joined multiple and often competing groups.

When Booth Gardner was elected Washington State Governor in 1985 he made health care his top priority. He re-organized the state's health care purchasing by consolidating several agencies into the new Secretary level Health Care Authority, appointed a health care commission to study and make recommendations on health care reform, and pushed hard to expand health care to the uninsured with the sliding fee scale Basic Health Plan. When he chaired the National Governors' Association (NGA) in 1990/91 he made health care its top priority. All these efforts fed into the Clinton's health care reform work.

Seattle was fertile ground for these seeds of change. The Greater Seattle Chamber of Commerce created a health care working committee in 1982 to address employers' concerns over rising health care costs. In 1983, this working group became the Health Care Purchasers' Association (HCPA), one of the early business groups on health around the country. Formed by a grant from the Chamber and the Puget Sound Health Planning Agency, HCPA was a 501(c)3 non-profit composed of the major self-insured purchasers of health care, such as Boeing, Paccar, Puget Sound Energy, The Seattle Times, Washington Mutual Bank, among others. HCPA's goal was to use its purchasing power to influence the marketplace to contain costs. It did not allow providers or associate members.

Not only was the health care marketplace enduring systemic changes, information technology in general and health care in particular were experiencing rapid transitions from mainframe and proprietary organizational systems. These systems needed to interact with one another using evolving Internet applications. Added to these technological transitions were regulatory demands for privacy from HIPAA (Health Information Portability and Accountability Act) in 1996, and the work surrounding Y2K. The fear was losing data and interoperability by moving from 1999 to 2000. Despite the need for common ground and common standards, the technology and regulatory changes made health care information technology a landscape of shifting sands.

The approach the Foundation used in its early programs is significant because it established the culture and methodologies for future work. Perhaps the most important development from this early work was the Foundation's emergence as a recognized and trusted 'safe harbor' that researchers could use to test new ideas to improve patient care. The Foundation gained, in a very heated time of health care reform, a reputation of trust and collaboration, thus providing a vehicle and roadmap others could use to explore similar issues. In short, the 1980s and '90s were heady times for health care in the Pacific Northwest and the Foundation was not only in the thick of it, but became a major leader both locally and nationally.

II. The Foundation’s Birth: Three Pathways: Providers, Purchasers and Data

Stated purpose:

The Foundation for Health Care Quality is established and organized to promote high quality health care for consumers within the community.

The first inkling of the Foundation emerged from three people: Andrea Castell, RN, BSN, MBA, Executive Director, Health Care Purchasers Association; Jim Nell, Executive Director, Seattle Area Hospital Council (SAHC) and Richard (Rick) Rubin, President and co-founder, EconoMedrics, a health care information services firm focused on quality measurement, management and health policy. The year was 1987. Utilization Review (UR) and Quality

Measurement were the latest cost containment buzz words touted as the means to control health care costs. These approaches, however, caused pain and consternation in the provider community. The Seattle Area Hospital Council was trying to find the best way to deal with these new initiatives. EconoMedrics was working with HCPA to find the best ‘electronic’ approach to compare utilization rates and develop meaningful quality measurements HCPA could use to establish standards, as well as have data to purchase health care based on value.

Castell, Nell and Rubin wanted to find ways to collaborate on these issues rather than leave them to the usual fragmented, separate stakeholders. They quickly realized that in order to move forward with meaningful work, they first had to address the issue of trust—a most elusive feature in a competitive health care market. They began discussions on a very high level and hosted a series of meetings with the State Hospital Association (WSHA), the State Medical Association (WSMA) and other practitioners to discover what they might be able to do collaboratively. It was not immediately obvious what they could do. An issue that kept recurring from most of the key players was ‘severity of patient illness.’ Severity of illness had a direct impact on the financial bottom line for physicians and hospitals as well as patient outcomes. The issue was most often framed as: “My patients are sicker than everyone else’s; therefore, your measurement process is not accurate.”

At that time, severity of illness criteria was determined by private severity vendors. These vendors took hospital data on cost, payments, outcomes and length of stay then scored that data on the severity of the patient’s illness. Few in the medical and purchasers communities, however, had confidence in these methods. When the data from the vendors were used to rank the same patients, they often had completely different scores. This broad based concern about vendors led Castell, Nell and Rubin to host a conference on severity adjustment systems.

Prior to the conference, they conducted a survey on Patient Severity Classifications Systems and Non-Severity Quality Assessment Systems to determine the relative use and provider satisfaction with those systems. The resulting conference was held in May 1987. Satisfied participants wanting to continue to the collaboration, led an effort to identify and define key elements to assess quality—clinical information, data needs on clinical information, and quality and performance measures.

Because Castell, Nell and Rubin wanted to build a collaborative model, they believed a neutral organization that was separate from and not embedded in any existing stakeholder

Founding philosophy:

Voluntary, cooperative efforts by purchasers and providers to promote health quality will be more effective than, and preferable to, government intervention through prescribed regulatory standards.

organization was essential for the success of that work. In December 1987, they recruited WSHA (Washington State Hospital Association) and WSMA (Washington State Medical Association) to join with them to form The Foundation for Health Care Quality. Each founding organization—HCPA, WSMA, SAHC, WSHA—made an initial commitment of \$5,000 to fund the Foundation’s early work. The Foundation was formally established and its bylaws adopted on March 17, 1988. Ernst and Whinney (now Ernst and Young) filed a 501(c)3 application with the IRS. The Washington State Hospital Association housed the Foundation’s offices and contributed in-kind salary support for interim Executive Director, Keith McCandless.

In December 1989, the Foundation adopted the following definition of quality from the National Office of Technology Assessment: *The quality of medical care is the degree to which the process of care increases the probability of outcomes desired by patients and reduces the probability of undesired outcomes, given the state of medical knowledge.* In 1991, that quality definition was changed to: *Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired outcomes, consistent with current professional knowledge.*

After the inaugural May conference, the Foundation hosted a series of additional conferences on a range of issues around electronic data and quality. These conferences generated income for the Foundation in addition to creating visibility for its work. They also served as trust building forums by the nature of the content and backgrounds of participants—purchasers, providers and hospitals—who were able to identify and share some common goals.

At this time the first Board committees for Administrative and Technical Review were also formed.

Providers: Clinical Research

Simultaneously, some new programmatic efforts were underway that would set the tone and the template for other Foundation programs. One of these efforts was related to the concerns about severity vendors and their ability to actually predict outcomes.

In 1988, the Foundation received a \$25,000 grant from the Group Health Foundation to conduct a pilot study on severity adjusted risk indicators. James LoGerfo, MD, Director, Robert Wood Johnson Foundation Clinical Scholars Program at the University of Washington, and Medical Director, Harborview Medical Center, served as the principal investigator. He appointed a technical advisory committee to help examine six of the severity vendors in terms of reliability, limitations, costs, and proposed new capabilities. The study included a literature review on outcome indicators and work with an expert panel. The study’s goal was to answer the question: “Is severity indexing combined with outcome measures, useful in assessing quality of care?” This was one of, if not the first, research studies to include patient outcomes with risk adjusted quality measures to identify meaningful quality indicators.

One of the outcomes was the formalization of policies for the release, confidentiality, distribution and application of data. Severity vendors were recognized as being inadequate to determine quality in many disease categories because there was little relationship of severity to outcomes. A tremendous amount of research was needed, however, to document the usefulness of severity indexing in various disease categories. The final report recommended that the Foundation undertake research which would focus on a few common, well understood conditions or procedures as a starting point.

Armed with this study on risk adjusted quality indicators, LoGerfo approached the Washington State Department of Health to partner in a study on maternity care because of the growth of C-section deliveries. The new study, StORQS (Statistical Obstetrics Review Quality System), used the new risk adjusted quality indicators to analyze and merge three data sets: birth certificates (which were rich in prenatal care and complications data); data from the state's CHARS (Comprehensive Hospital Abstract Reporting System) for the same birth; and data from infant death records, which had never previously been linked with birth records. They also worked nationally with JCAH (Joint Commission on Hospital Accreditation—now JCOA—Joint Committee on Accreditation) which had similar concerns about the growing rate of C-sections.

By merging these three data sets, LoGerfo's team could produce a risk adjusted report and create indicators for quality of care that could be presented to hospital medical staff. Their new data also enabled them to identify indicators on the probability of C-sections. The data not only showed statewide averages, but also included hospital-specific data. Reports could also be produced to determine whether there were statistical differences between expected and actual outcomes.

The StORQS study was one of the first of its kind in the country to link clinical data to patient outcomes and establish quality measures based on that information. The production of this data, however, raised the issue of how the data would be presented and shared with the participating hospitals and providers.

In the first study, hospitals saw only their specific data and aggregated statewide data. Individual hospitals were not publicly compared with each other. LoGerfo found some hospitals had terrible coding problems especially around infant skull fractures. As a result of these findings, the research team created a reporting system that identified indicators to suggest when to send an infant to neonatal intensive care, as well as create a data system that was a useful learning tool for hospital medical staff. Because the work was not punitive to hospitals or doctors and because hospitals could see how they ranked against statewide quality standards, the hospitals continued to participate in the second study. By the second year, outlier hospitals had changed their care patterns and by the end of the study gave permission for the participating hospitals to be identified by name.

StORQS set some programmatic standards for the Foundation: 1) the initiative was physician-driven using clinical data; and 2) data was confidential until hospitals and providers were ready and comfortable with releasing data.

The StORQS study's critical finding was: it was possible to create risk adjusted measures and apply them to quality outcomes. This was significantly beyond quality measures developed to date. The only other comparable quality measures were those developed by the Society of Thoracic Surgeons.

At one point, StORQS sought funding to continue its work and proposed future financing by receiving \$2 per birth from participating hospitals. They were ultimately unsuccessful in that approach.

To further test the feasibility of using the StORQS approach to other clinical areas, Richard Deyo, MD, MPH, another University of Washington Robert Wood Johnson Clinical Scholar, focused his interests on low back pain. Called BOAT (Back Pain Outcomes Assessment Team), the study was designed to evaluate variations in care patterns for back pain. BOAT, which was part of a larger project by the Agency for Health Care Policy and

Research (now Agency for Health Care Research and Quality), in Washington DC, had a range of deliverables including patient and provider engagement models, patient decision support, and standards for measuring back conditions. BOAT used the StORQS model in its research design to determine if the quality measures developed in StORQS would be applicable to other clinical specialties.

Logerfo, Goss and Whitten had all been involved with the University's Robert Wood Johnson Foundation's Clinical Scholars program. They knew of each other's work, so when the HCA and others began looking at contracting criteria, Whitten turned to them for help.

StORQS and BOAT were the predecessor to COAP founded in 1993, a year after StORQS completed its work. Richard Goss, MD, a Robert Wood Johnson Foundation Clinical Scholar working with LoGerfo, was interested in the question: "What pre-surgical procedures had an impact on surgical outcomes?"

At the same time, significant pressure was building in Washington State to direct cardiac surgery patients to 'Centers of Excellence.' To determine what might constitute a 'Center of Excellence,' the Health Care Authority (HCA) sent out an RFI (Request for Information) to hospitals across the state to learn what they would consider to be the criteria for Centers in Excellence in Cardiac surgery. When the hospitals returned their materials, Richard Whitten, MD, Medical Director for the HCA and others reviewed the data, they found no indication there were any problems in cardiac surgery. The data showed that regardless of volume, quality was evident in all cardiac surgery sites. What they did find, however, were access problems. If the HCA directed patients to Centers of Excellence, it would have major impact on the availability of services, especially in more rural Eastern Washington.

Whitten and Goss were introduced based on their shared interests and together they created a program called COAT (Cardiac Outcomes Assessment Team). COAT was an independent effort to examine cardiac surgery outcomes with funding from the HCA, VA, HSR&D and funds from the Health Services Commission. Whitten, Goss and a management team were able to analyze the data on outcomes and determine criteria for cardiac surgery.

This was no simple task. The study began not long after comparative cardiac surgery data was handed over to the press in New York State under the Freedom of Information act. The public sharing of confidential hospital and clinic records, right down to the particular physicians, sent shock waves through the medical community. Whitten and Goss were concerned they would not find physicians and hospitals willing to risk sharing their data.

The HCA ended up suspending its selective contracting and instead worked with Goss and his colleagues to create a medical community collaborative approach to cardiac surgery. HCA also required every hospital that contracted with them for cardiac surgery to use the severity adjusted data used by the Society of Thoracic Surgeons or the risk adjusted data/protocols developed by the Foundation through StORQS. While this was not a legislative mandate, participation was not voluntary. If the hospitals did not participate, however, they could not contract for services with the HCA.

Goss had been looking at cardiac surgery outcomes in the COAT project. But COAT did not have a home. They renamed COAT to COAP, and looked to house it in the Foundation. The Foundation had received a grant from

the John A. Hartford Foundation in 1994, which could support the COAP study to examine clinical outcomes from coronary bypass surgery and to demonstrate a collaborative method in the collection, analysis and dissemination of outcomes data. After the successful completion of the pilot, COAP added percutaneous coronary interventions (PCI) as well as coronary bypass surgery to its scope of work.

StORQS, BOAT and COAP all set the tone, methodology and template for future Foundation programs. The major learning was: physician-driven research using clinical data created learning tools physicians and hospitals would actually use to improve patient care.

“Not only did such work improve care, it reduced costs. SCOAP (Surgical Care Outcomes Assessment Project), which was modeled in large part around COAP’s function and structure in 2003, reported that in the first three years of launching, SCOAP methods and programs saved more than \$50 million by reducing complications and improving efficiency.”

-Life Sciences Discovery Fund Now, Washington State, February 2010.

This early work preceded the Institute of Medicine’s Crossing the Quality Chasm report that appeared in 2001. The IOM was interested in COAP’s work and invited members to attend a meeting on the future of quality of care, prior to issuing its report. IOM could also see a future for physician reporting and outcomes as part of IOM’s services.

While these clinical models were being developed, refined and expanded, the purchasers were on a parallel path to use the promise of information technology to make more informed purchasing and contracting decisions, and thereby control costs.

Purchasers: Purchasing Value

When the Health Care Purchasers’ Association (HCPA) formed in the early 1983, its members wanted to find ways to use their size and purchasing power to influence the health care marketplace. HCPA was one of the early business groups on health that would later bloom across the country. It was also active with other Business Coalitions on Health including the National Business Group on Health (NBGH) in Washington DC. The NBGH had been working with the John A. Hartford Foundation on ‘Information for the Purchasers’ of Health Care’ and ‘Rational and Uniform Data Collection Among State Health Care Agencies.’ Rick Rubin of EconoMedrics had been retained by HCPA to work on data measurements, quality and technology issues. Because HCPA members were all large, self-insured companies, such as Boeing, Washington Mutual Bank and Weyerhaeuser, they had ready and robust access to their employees’ health data.

Prior to joining the Health Care Purchasers’ Association, Castell worked at PRO-West (now Qualis), which evolved from the State’s PSRO (Professional Standards Review Organization). Several years earlier, the Washington State Medical Association had given rise to the Washington State Professional Standards Review Organization (WPRSO) to monitor the cost and quality of health care for Medicare and Medicaid enrollees. PRO-West (which evolved from WPRSO) worked with Medicare and Medicaid on concurrent hospital utilization review and with hospital quality of care audits called MCEs (medical care evaluation studies). When the employer community learned of the PRO-West work, they wanted to apply the same approach to the private sector. Castell and PRO-West subsequently worked large self-funded employers to include Boeing and the states of Washington and Alaska to look at the utilization patterns of private sector employees, not just Medicare and Medicaid enrollees.

From its beginning, WPSRO required the completion of a data patient abstract for every hospitalized patient. WPSRO was the largest data repository in the state outside of Medicaid. The purchasers thought having comparable data would be invaluable to employers because they could use the employee health data to make better informed purchasing decisions.

Data: Health Care Information System Infrastructure

Hundreds of millions of dollars have been spent nationally on health care information systems. The evolution of these systems was not only caused by health care reform, such as moving from fee-for-service to managed care, but also by regulatory and technology changes as well. Between 1980 and into 2000, data systems experienced continuous technology changes. Most information systems up into the early 90s were internal proprietary mainframe systems. As health plans merged or partnered to create the new PPOs and other managed care systems, their respective systems needed to communicate with each other. One problem, for example, was mergers. If one health plan was PC based and the other Apple, their systems could not 'talk' with each other. The advent and expansion of the Internet dictated constant and rapid evolution of information systems and their applications.

Adding to the technological changes, major regulatory demands emerged, such as HIPAA (the 1996 Health Information Portability and Accountability Act). HIPAA set broad and detailed privacy standards for patient health care information. The depth and breadth churned workloads and set high standards for privacy throughout the system. Adding to regulatory changes was the fear of what would happen to computerized information because of the move from 1999 to 2000 (Y2K). It seemed not a month went by, when hospitals, plans and physicians did not have to make significant information system changes, all of which were costly.

Because purchasers wanted data in order to make value based purchasing decisions and because clinicians needed data to make informed clinical decisions, the demand for accurate, meaningful data exploded. New models of health care reform emerged that pooled patient data in a specific geographic area in the hopes of lowering health care costs. Pooling patients, however, meant that different health care organizations in the geographic areas had to share data. These HIPCs (Health Insurance Purchasing Cooperatives—the fore-runner of the proposed 2010 'health insurance exchanges') meant that participants had to decide on how to share data without divulging or compromising proprietary information or patient privacy.

The Foundation became a national leader in this endeavor.

III. Fortuitous Convergence: Vision *and* Funding

Meanwhile on the east coast, a private foundation wanted to use marketplace approaches to control costs and improve quality of care: the John A. Hartford Foundation in Connecticut. The Hartford Fund, established in 1929 by John A. and George Hartford of the Great Atlantic and Pacific Tea Company (A&P) focused on "the greatest good for the greatest number." Formally incorporated as a Foundation in 1942, Hartford supported projects in health care. Since 1995, its work has been completely devoted to elder care and geriatrics.

In the late 1970s, the John A. Hartford Board of Trustees was alarmed at health care cost increases. In 1979 the trustees started an initiative to contain costs by influencing the marketplace and by increasing provider effectiveness. Richard Sharpe, Program Manager for John A. Hartford Foundation's marketplace and quality initiative, was a proactive Program Director who went around the country finding thought leaders, organizations and business groups working on these issues. Between 1979 and 1995, the John A. Hartford Foundation invested \$60,903,580 in 144 grants to support their initiatives.

John A. Hartford Foundation gave first dollar support to Donald Berwick, MD, CEO, Institute for Health Care Improvement (2010 Administrator, CMS—Centers for Medicare and Medicaid in the Department of Health and Human Services); John Wennberg, MD, Dartmouth working on clinical practice variations; and to Interstudy, with Paul Ellwood, for managed care efforts. It was the first funder for the National Coalition on Health Care in Washington DC, a Coalition of many other business coalitions across the country. A review of their grants is snap shot of the major thought leaders of managed care, quality of care, variations in care and value-based purchasing, not to mention leaders in developing community information systems.

John A. Hartford Foundation gave seed money and core support for some groups, and funded studies ranging from 'Medicaid Managed Care' to 'Controlling Hospital Admissions' and 'Bench Marks for Cost-Effective Care.' It also supported groups ranging from the RAND Corporation and the Mayo Foundation to Ohio Corporation for Health Information. The John A. Hartford Foundation gave its first grant of \$100,000 to HCPA in 1990 to develop an 'Employer-Sponsored Managed Care System' and the first grant to the Foundation for Health Care Quality in 1990 for \$331,000 to develop a 'Health Care Effectiveness Information System,' which supported some of LoGerfo's early work.

The early 1990s saw the convergence of clinical quality measures to impact care with the need for community health data for the anticipated HPCs. The hope was to create comprehensive electronic networks to access and exchange information needed by the various stakeholders. Information was to come from data registries, vital statistics on birth and death and certain hospital discharge data; sources that LoGerfo had used in the StORQS study. To do so required community-based health information systems.

In 1991, the John A. Hartford Foundation sponsored a new path within its quality initiative: Community Health Information Management Systems initiative (CHMIS). HCPA, which had received an earlier grant on Employer Sponsored Managed Care, was awarded another \$400,000 to create a 'Community Health Management System (CHMIS).' This grant to the Foundation made Washington one of the seven communities participating in the CHMIS initiative: six states—Washington, Iowa, Minnesota, New York, Vermont and Ohio, and one metropolitan area: Memphis, Tennessee. CHMIS focused on sharing information between and among organizations. Sharing data raised many sensitive issues including who to share with, what to share, and how

to keep information secure and private. Because most systems were private business ventures, many groups were reluctant to share their proprietary data. Because so many groups had their own information systems, one problem was simply how to make data interchange possible. In the late 80's and early 90's a tremendous amount of time and effort went into standardizing data. But as Electronic Data Interchange (EDI) was burgeoning, it became a big business driver. Most health care organizations, except for staff model HMOs like Kaiser Permanente or Group Health Cooperative, could not easily capture much clinical data. Non staff model HMOs had tremendous challenges including how to obtain information on lab tests, x-rays, prescriptions and all the things that happen outside of a hospital or outside physician's office. All this data was on paper crammed files stuffed on shelves in thousands of clinics. This remains a challenge of incredible magnitude given that over half of the 650,000 physicians practice in offices of four or fewer doctors.

The CHMIS movement spearheaded by the John A. Hartford Foundation was a sweeping, national movement and the Foundation for Health Care Quality was at the heart of it. The CHMIS goal was to collect accurate clinical data in a timely manner for providers and purchasers; share data; develop clinical measures to improve quality; reduce costs, and enable employers to purchase value.

Hundreds of millions of dollars were spent trying to develop health care systems that could talk with each other. Data standards and protocols had to be developed and agreements reached on what would be shared. Then there remained the ever present problem of trust and finding consensus.

Approaches from mainframe technology were also converting to Internet applications. So, not only were data standards being developed, they were changing as quickly as they were agreed upon. New Internet protocols and applications raised a whole new set of issues on data security and privacy.

Between 1991 and 1995, the Foundation received \$4,633,850 from the John A. Hartford Foundation in addition to its earlier grant, to be the leader of a CHMIS National Resource Center. This resulted in a new final grant for \$2,053,909 to create the Health Care Quality Measurement Advisory Service (QMAS) which assisted state and local health care coalitions, purchasing groups and health information organizations to measure health care quality for value-based purchasing and related purposes. QMAS was a joint collaboration of The Foundation for Health Care Quality, the National Business Coalition on Health and the Institute for Health Policy Solutions in Washington DC.

Despite their robust investments, the John A. Hartford Board of Trustees ultimately saw few of their marketplace efforts gaining traction in containing health care costs and they saw more failures than successes in CHMIS. Consequently, the Trustees formally ended their marketplace and quality program in 1995, with 1998 being the final year of grant funding. In total, the John A. Hartford Foundation awarded 144 grants totaling nearly \$61 million for its marketplace and quality initiative between 1979 and 1995.

The CHMIS work was continued in part by two subsequent grants from the Robert Wood Johnson Foundation: The Three State project to model Internet protocols, develop standards and develop community health information networks and the HealthKey project focusing on a creating Public Key Information (PKI) through which information could be transmitted, secured and shared. While the work on HealthKey was ground breaking, after September 11, 2001, Robert Wood Johnson shifted its funding to public health infrastructure and bioterrorism and away from community health information exchange.

This is an extremely short and simplified synopsis of a large, complex, complicated, politically delicate, yet visionary effort. The history of CHMIS, CHIN and HealthKey is beyond the scope of this report. Many excellent reports emerged from this critical period. A few are outlined in Appendix Two. Ironically, the Foundation's work on CHMIS/CHINs paved the way for the work on the Electronic Medical Records (EMR) and the meaningful use initiative being asked to be complete by 2014 and finally funded by the reform legislation that passed in 2010. The CHMIS vision was 20 years ahead of its time in terms of the readiness of the stakeholders to collaborate much less share data and ahead of the technology to support the vision. Without CHMIS, however, none of the stakeholders would have moved as far as they had and the technology to support the vision would not be where it is now without this early efforts and collaborations.

The loss of both John A. Hartford Foundation and Robert Wood Johnson Foundation grants was a major blow to the Foundation, its programs and funding. In addition, the Dot.com bust of 1999 doomed many organizations and left others in precarious positions. Rubin left the Foundation in 1999 to continue work in technology applications. He was replaced by Elizabeth Ward, former Assistant Secretary of Health, who faced an extremely challenging time financially within the Foundation. The original and robust funding sources for the Foundation were gone. WSHA and WSMA no longer paid dues to the Foundation. HCPA and SAHC, the other two founding partners, no longer existed. The CEO position was moved from fulltime to part-time, and major changes were made in funding sources, methods and financial reporting. Ward was instrumental in moving Pacific Medical Center's Cross Cultural Health-Care Research program and its \$800,000 four year grant to the Foundation, prior to her move to director of the Community Health Information Technology Alliance (CHITA).

"Partnerships grew the Foundation for Health Care Quality. While Jim and Rick and I thought some type of joint effort to look at quality was a great idea; the Foundation would not have become reality without Leo Greenawalt at the Washington State Hospital Association, Tom Curry at the Washington State Medical Association, the employer members of the Health Care Purchasers Association and the financial backing of Dick Sharpe at the John A. Hartford Foundation. It's true...people not principles move the age."

-Andrea Castell, Ex. Director,
Health Care Purchasers' Association.

Staff salaries for the Foundation programs became dependent on participating members' dues, conference registrations and sponsorships for the Foundation's programs, not the Foundation itself. Financial stability impacted programs. 1988 until 2010 only one program director has been fulltime. The only other fulltime position at the Foundation is the Administrative Manager who supports the CEO and all the Foundation's programs.

The Foundation's funding was so uncertain that at one point in 2000-2001, Dorothy Teeter, Interim CEO after Elizabeth Ward, even considered merging the Foundation with another organization. She and the Board finally called off the merger because they believed the critical piece unique to the Foundation's culture—the safe table, neutral culture—would have been lost.

As the John A. Hartford Foundation funds wound down, however, the Foundation's value had been recognized and their programs grew and new ones emerged: COAP in 1994; CHITA in 1996; Washington Patient Safety Coalition in 2002; and SCOAP in 2003. The Foundation has also been a home for special studies, such as ODIN (Outbreak Detection Information Network) and a resource to the State, such as the Washington State Department of Health's Diabetes Collaborative, the Health Care Authority and city and county Departments of Public Health, among others.

That the Foundation has fared tough times, is attributable to its reputation and culture. This sustainability is a tribute to individual members of the medical profession who had the vision and passion about patient care and their ability to attract other partners and programs to focus on a wide variety of quality initiatives. It is also a tribute to the dedicated program directors and CEOs. This passion and vision are the Foundation's life blood.

The continuing challenge facing the Foundation is financial sustainability. Yet, participants continue their involvement in the Foundation, and new principal investigators continue to come to the Foundation as a home for research they cannot do elsewhere. Somehow, the funding continues through projects and/or grant support. The Foundation's programs continue to have an impact. Delightfully, documentation is increasingly forthcoming not only on quality outcomes and learning tools, but also on the cost savings quality care has for the system as a whole.

“The only reason we were successful was the receptivity of local leaders to a collaborative approach. The Washington health community was fertile ground for collaboration and still is. The three of us could have done exactly the same thing in many other places and we would have failed. I give much credit to Tom Curry, WSMA and Leo Greenawalt, WSHA, and the Foundation’s first Board Chair—Phil Nudelman, then CEO of Group Health Cooperative. We had the idea—they were the ones who took the risk and gave it life.”

-Rick Rubin, CEO, OneHealthPort and former CEO,
Foundation for Health Care Quality.

IV. The Founders: A Yeasty Confluence

“The formation of the Foundation showed the early commitment of doctors and hospitals to sharing information in order to support high quality in health care. WSHA was pleased to be a part of this early action to improve care.”

-Leo Greenawalt, President and CEO,
Washington State Hospital Association.

In looking at an organization, it helps to go back to the minds and thoughts of the founders who took a risk to start something new. In the case of the Foundation there were several key founders: Castell, Rubin, and Nell who saw the need for such an organization, the first board members who were to shape the Foundation’s growth, and the founding organizations that funded the initial vision.

A wonderful confluence of interests sparked the collaboration of Castell, Nell and Rubin. Castell was a nurse with an MBA, so she brought both clinical and managerial interests to her work. Her experience with WPSRO and PRO-West which operated in Region X (Alaska, Idaho, Oregon and Washington), led PRO-West to try the same WPSRO work in Alaska. At the time, Rubin worked for the Teamsters in Alaska which is where he and Castell first met. He was interested in using the WPSRO data model for the Teamsters. When Castell became head of HCPA and Rubin joined EconoMedrics, she hired him to help the large healthcare purchasers on similar data initiatives. Because of her work at PRO-West contracting with hospitals, she knew Jim Nell, who headed the SAHC. The three started working together shared similar interests and thought there could be a way to get people to work together collaboratively. So they chose quality—because who could say no to that?

Their common work with hospitals, physicians and data systems provided a shared interest in health care informatics from a variety of perspectives. Castell for employers; Nell for hospitals; and Rubin in data management and systems, but from the point of view of the patient/consumer which came from his work at the Teamsters.

This confluence of interests and experience led them to find ways to create a neutral organization where people could share their concerns and ideas and learn from each other. This blossomed into the first severity vendor conference and future meetings. They met with the leadership of the state medical and hospital associations, and the rest, as they say, is history.

The Foundation was officially created on St. Patrick’s Day, March 17, 1988. The founding organizations agreed to donate \$5,000 each, provide two representatives to the founding board, and offer in kind assistance when possible. The founding board members were:

Washington State Medical Association: Jeffery Clode, MD, Internist, Spokane; Joseph Nichols, MD, Orthopedic Surgeon, Tacoma; **Washington State Hospital Association:** David Bjornson, Administrator, St. Peter Hospital, Olympia; Michael Wilson, President, Holy Family Hospital, Spokane; **Seattle Area Hospital Council:** John

Bencich, Associate Executive Director, Swedish Hospital, Seattle; Phil Nudelman, Executive Vice President, Group Health Cooperative, Seattle; **Health Care Purchasers Association**: V. Marc Droppert, Director of Compensation and Benefits, PACCAR, Inc., Bellevue; A.H. “Bud” Towsey, Executive Vice President, First Interstate Bank, Seattle.

An informal steering committee provided staff work to activate the Foundation and assume staff responsibilities until the Foundation could afford staff. The Steering Committee members were:

Andrea Castell, Executive Director, Health Care Purchasers’ Association; Tom Curry, Executive Director, Washington State Medical Association; Leo Greenawalt, President and CEO, Washington State Hospital Association; David Kiehn, Senior Manager, Ernst and Whinney; Keith McCandless, Policy Planning Specialist, Washington State Hospital Association; Jim Nell, President, Seattle Area Hospital Council and Rick Rubin, Executive Vice President, EconoMedrics. During the early years, WSHA donated both staff time and office space to the Foundation.

In 1988, Keith McCandless became the acting Executive Director as an in-kind contribution of WSHA.

This rare confluence was an unusual and effective combination of time, talent and collaboration—which may be one of the reasons the Foundation has thrived and survived for so long. People who have passion for patient care, patient safety and quality improvement continue to approach the Foundation with new ideas.

The vision and lesson these three people brought to the table was if you give providers good information, with clear data, they will change their behavior. How to get that data from clinical records accurately and electronically was one of their core and continuing challenges.

V. Community Impact

The Foundation's programs have demonstrated positive impacts in Washington State and nationally. The Foundation's current programs can be organized into three tracks: 1) physician-driven clinical track (StORQS, BOAT, COAP, SCOAP); 2) information technology tracks (CHITA), and 3) consumer/patient track (WPSC). It also periodically oversees special projects.



COAP (Clinical Outcomes Assessment Program)

Richard Goss, MD, had been a Robert Wood Johnson Clinical Scholar at the University of Washington School of Medicine, consequently he knew of LoGerfo's StORQS project. Goss was interested in examining variation in cardiac surgical outcomes and thought the StORQS study offered an interesting approach. The first study called COAT (Cardiac Outcomes Assessment Team) was funded in part by the HCA and the VA HSR&DHSRD grants to help develop criteria on cardiac surgery across the State when the HCA had been looking at creating Centers of Excellence to assure patients were directed to hospitals providing high volume care. Physicians thought such state mandates were a government intrusion into their autonomy. Additionally, health care providers across the state were understandably nervous because of the public sharing of comparative medical data in New York.

With Goss's work as an RWJ Clinical Scholar coming to an end, he wanted to find a home for COAT. Whitten and Goss approached the Foundation about housing his research efforts. Goss wanted to engage in policy work. He was also interested in work beyond the halls of academia. He wanted something that could impact public policy and be analytically rigorous. Goss's research had led him to the New England Study Group which was a collaborative, physician-led group working on improving cardiac care. He thought that this group's work resulted in a useful model. Policy staff in Olympia, however, had concerns about physicians interpreting their own data—an approach some thought not unlike foxes guarding the hen house.

Goss and Whitten were trying to find some way to create a collaborative study, and if possible, to engage policy makers in Olympia. They approached other cardiologists and cardiac surgeons who supported this approach. They were able to attract a group of cardiac surgeons from 13 different hospitals to form a physician-driven collaborative that would work hand in hand with the state to develop an analytical, consensus driven approach to cardiac care rather than just focusing on mortality. They changed the name from COAT to COAP (Clinical Outcomes Assessment Program).

Because of the New York experience, the first COAP study looked at a broad range of patient reported outcomes, rather than a focus only on mortality data which was a subject of much controversy. It was also a voluntary effort, not a legislatively mandated effort. The study showed that patients reported significant improvement in quality of life six months to one year after surgery. There were no indications these improvements differed statistically across surgical sites. This was also the first time the state had used data other than CHARS in their studies.

As a result of this study, the Health Care Authority abandoned its 'centers of excellence' approach to cardiac surgery and instead required that all hospitals under contract with the HCA for cardiac surgery use the tools

and guidelines developed by COAP. Data collection was changed to strictly clinical data, and a broad array of procedural and hospital-based outcomes data were examined. Unfortunately, longitudinal patient satisfaction measures for such a large population of patients could not be included because of cost and logistical limitations. The HCA and other state agencies also gave the Foundation a \$100,000 grant to pursue this work.

“COAP was successful because the process, analysis and methods were well received. It was not a front page of the Seattle Times score card. Our open process and the broad array of participants from a range of hospitals gave us credibility. Physician leadership was essential,” Goss observed.

“We asked questions people wanted answers to: What is the best approach for dealing with patients who are diabetic? What is the best approach to transfusion management? What do we know about these new technologies and the impact of stents on platelets? What is the best approach to prevent dialysis and strokes? COAP was able to contribute meaningfully to these and other questions,” Goss indicated.

COAP Community Impact

In 1997, COAP was presented to the State Interagency Quality Committee and was endorsed as an HCA-sponsored quality improvement activity and was subsequently registered with the state Department of Health as a Certified Quality Improvement Program (CQIP), providing discovery limitation during lawsuits under Washington State statute. COAP continues to offer statewide programs and periodic meetings to engage the cardiac community; it provides quarterly and annual reports with selected risk-adjusted quality indicators. COAP, which began with 13 hospitals has grown to include over 30 hospitals providing cardiac procedures. By 2010 there was universal reporting from all hospitals that perform cardiac surgery and percutaneous coronary interventions.

“In my 36 years as a physician, 18 in critical care, 12 as Medical Director of Washington’s Health Care Authority and Basic Health Plan and now 11 as Medicare Medical Director, I have consistently felt the concept and processes set up in COAP and now also continuing in Surgical COAP (S-COAP) are the most important and promising activities for improving clinical care quality I have known. The physician guidance is key; they must be involved, must help identify issues, concerns and measures, must participate in collection of the data, assure its validity and then share in its dissemination, with analysis leading to real – and measurable – quality improvement.”

- Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director, DME MAC D.

COAP has documented the following statistically significant improvements: decreased time on ventilators; increased use of internal mammary artery grafting and reduced blood use during cardiac surgery; and lowered door to balloon times with acute heart attacks. It also serves as a national model for collaborative, physician led efforts which holds institutions accountable for their cardiac outcomes.

While the early data were not shared with the public, since 2008, the data is published annually and clearly posted on the Foundation’s website. <http://www.coap.org/public/index.html> “This greater transparency of data has led the continuous improvement care. On the rare occasions when there are data of concern and services seem to be heading in an unfavorable direction, the transparency usually leads to a rapid and robust response,” Goss observed.

COAP was also able to undertake other projects, including several on diabetes testing and management with the State Department of Health and working in collaboration with PRO-West (now Qualis) on a cardiovascular collaborative for atrial fibrillation management. An excellent example is reduction in blood transfusions.

COAP Funding: COAP's programs are funded by membership dues and grants.

COAP: What's Ahead? COAP now not only to continues to work on quality, but is asking more fundamental questions such as are these appropriate cardiac services? Should we be doing them at all?



SCOAP (Surgical Care and Outcomes Assessment Program)

SCOAP was launched in 2003 with a feasibility study examining the efficacy of applying the COAP methodology to surgical procedures not specific to cardiac care. Like COAP, SCOAP is endorsed as an HCA-sponsored quality improvement activity and is registered with the state Department of Health as a Certified Quality Improvement Program (CQIP).

Also like COAP, the program is a collaborative, data driven and physician led initiative. Its goal is to ensure that surgical care in Washington State is appropriate, safe, effective and cost-effective. Its results have been impressive. SCOAP has saved \$50 million since its inception by reducing complications and errors in surgical practices. (*Life Sciences Discovery Fund Now*, February 2010).

David Flum, MD, was the architect of SCOAP. Having been a Robert Wood Johnson fellow in 2000, Flum met and worked with Richard Goss and became interested in what Goss was accomplishing with COAP. Flum's research efforts focused on the wide variability of cost and outcomes for bariatric surgery. Trying to understand the causes of the variability was daunting.

In 2005, Flum was able to persuade Nancy Fisher, MD, Medical Director, Health Care Authority and Jeff Thompson, MD, Medical Director, Medicaid, in DSHS (Department of Social and Health Services) to fund SCOAP to conduct a baseline economic data analysis of bariatric surgery using CHARS data. The program started with five hospitals in 2004-05. These early years were quite collaborative and the new energy, enthusiasm and collaborative participation enabled the program to grow from the five early hospitals, to 16 by 2006—all within one year.

"This was an exciting time as we were building the program. We now had more surgeons coming on board who were willing to join our Advisory Board. With this work under our belt, we were able to demonstrate the validity of our approach and our finding which led to our \$1.3 million grant from the Life Sciences Discovery Fund in 2007," Flum observed.

The Life Sciences grant enabled SCOAP to expand its activities to recruit 55 hospitals. To accomplish this, SCOAP partnered with the University of Washington's SORCE (Surgical Outcomes Research Center) to be the analytic and academic home for the project.

“We began cautiously. We started with appendectomies then moved to bariatric surgery, and began addressing more complex clinical procedures. What we found was that these studies were not just about quality and safety. Our methodology also enabled us to examine procedures in terms of effectiveness, outcomes and appropriateness of care. This means we could bring in the entire spectrum of clinical disciplines,” Flum stressed.

The research methods and analysis through COAP/SCOAP enabled the creation of benchmarks for *procedures and performance*, not just outcomes. Participants can examine the entire process of care procedures to determine how the best performers become the best performers. Having benchmarks, as Flum said “gave us something to chase.”

In 2009, SCOAP, with many partners, rolled out its most visible initiative—the Surgical Checklist. Modeled after the checklist used by pilots on commercial airlines, this checklist is now in every Washington State hospital. Washington is the first state in the nation to make this happen. This list assures the entire surgical team reviews each step in the upcoming surgery at the same time and prior to the surgery itself.

“We want to build real grass roots energy to engage doctors in the state. Our Surgical Check List is now in every hospital in Washington State. We have also moved from just reporting on outcomes to changing behaviors by using benchmarks appropriate to the best practice,” Flum indicated. “The Foundation’s real gift to the community is offering a venue where you can take ideas and turn them into action.

“The early safety and quality work were a wonderful warm up to determining appropriate and cost-effective care, especially the use of expensive technologies. We can only do this with an engaged physician community,” indicates Flum.

SCOAP is now busily working with payers to build a business case to create thoughtful incentives together with the physician community. SCOAP is trying to energize physicians in more engaging behavior and change monetary incentives to provide appropriate care.

SCOAP Community Impacts

SCOAP perhaps has had some of the most visible and tangible outcomes because it has the hospital data to show shorter length of stay and fewer re-admissions/re-interventions. Between 2003 and 2005, SCOAP reduced the re-intervention rate for colorectal surgeries from 7.2% to 3.2% and shortened the length of stay for elective colorectal surgeries by an average of three days. It also shortened the length of stay for gastric bypass operations by an average of 1.5 days. With the cost of bariatric surgery ranging from \$18,000 to \$35,000 savings to the individual and the system as a whole are considerable, not to mention improved patient care and outcomes.

While it may have been modeled on COAP, SCOAP would not have been born without the passion of its physician leaders: Mike Florence, MD, general surgeon, Swedish Medical Center and Chair, SCOAP Advisory Board (2006--) and David Flum, MD, a surgeon at the University of Washington Medical Center.

There has also been a cast of supportive advisors who have helped actualize this vision—surgeons like E. Patchen Dellinger, MD, Richard Thirlby, MD, Paul Lin, MD, and Foundation Board leaders like Peter Dunbar, MD and advisors like Nancy Fisher, MD, Medical Director, Health Care Authority and Jeff Thompson, MD, Medical Director, Medicaid, Department of Health and Human Services.

In 2003, the state was having considerable difficulties with expensive bariatric surgeries and their horribly high mortality and morbidity rates. The PEBB (Public Employee Benefits Board) had been approached to add bariatric surgery as a covered benefit. Because of the existing relationships with the Health Care Authority and the success of the COAP program, the HCA-funded a study to apply COAP methodology to surgical procedures. Flum headed the study, recruited the hospitals and became medical director of the new SCOAP in 2004.

SCOAP's work on colorectal surgery has reduced excess care costs caused by complications/re-interventions. Between 2003 and 2005, it reduced re-interventions in colorectal surgery from 7.1% to 3.2% and shortened the length of stay by three days on average for colorectal surgeries and another 1.5 days less in elective gastric bypass surgeries.

SCOAP Funding: Like COAP, SCOAP is funded largely by dues of the participating members and grants.

SCOAP: What's Ahead?

SCOAP's expansion to the full range of clinical conditions associated with high cost, high risk interventions is spreading to vascular disease, interventional radiology, spine surgery, gynecology and urology. Flum sees benchmarking and data-based improvements in quality and cost-effectiveness as the centerpiece of America's future health care system. SCOAP is a platform for use across all clinical disciplines.

"I have always watched David with amazement and amusement at what he has been able to accomplish from his early work on bariatric surgeries to getting the checklist in every operating room in every hospital in the state," Dunbar mused. "He has done a great job in a very politically delicate environment."



The Washington Patient Safety Coalition (WPSC)

The Washington Patient Safety Coalition (WPSC), a coalition of hospitals, health plans, professional organizations, medical groups and other organizations, individuals and agencies concerned about patient safety, is a relatively new initiative at the Foundation. Like COAP and SCOAP, the WPS is a state certified Coordinated Quality Improvement Program (CQIP).

WPSC grew out of the first Institute of Medicine Report: *Crossing the Quality Chasm* that reported on the 100,000 patients who die each year from preventable medical errors in hospitals. By 2001, when the report was published, both the Health Care Authority and the Department of Health knew of the Foundation's work and reputation as a neutral safe table and therefore became involved with the Foundation in 2001/02. The

Governor's Office approached Dorothy Teeter, the Foundation's Interim CEO, for help. Teeter attended a national meeting hosted by the Agency for Health Care Research and Quality on patient safety and the important role multi-stakeholder coalitions could play to improve patient safety.

Teeter returned from the meeting excited about the prospects of creating such a coalition in Washington State and convened an invitational conference in June 2002 as the first step in a broader statewide initiative. Leonard Marcus from Harvard University was the keynote speaker and led a training on "Interest-based Negotiation."

"Patient safety was an emerging issue for both health care providers and the public health system across the state and the country. It was an issue that seemed a perfect fit for the Foundation's leadership and focus: it was highly relevant and needed collaboration and sharing of best practices in order to start improving care. It also required good data to help set state priorities, and it needed consumer input and engagement to gain momentum as a key public health and health care issue. Maxine Hayes, MD, MPH, the State Health Officer, was fully engaged and provided an inspiring kick off for our opening event. Looking back, this event was an important milestone in the state and for the Foundation to work together on an issue that is still a top priority for protecting and improving the health of Washington State residents," observes Dorothy Teeter, Interim Foundation CEO, 2001-02.

The meeting's goal was to train some facilitators and have them work with the various stakeholders to find key consensus points around patient safety. A broad agreement emerged that patient safety improvement had to be statewide and that the Foundation would be the formal home—the participants believed it would be impossible to establish statewide priorities without such a neutral home.

After the inaugural conference, the Coalition took small steps. They began fundraising, drafted the mission and vision statements, held monthly meetings and began to identify patient safety priorities.

Most WPSC members are institutional members, but several individual consumers have joined. Leadership is provided by a 15 member steering committee of representative stakeholders—hospitals, providers, associations and groups like the Community Health Plan of Washington. A challenge in engaging consumers on the Coalition is that they often can be single issue advocates vs. patient safety issues on the whole.

WPSC Community Impact

The first project was on "wrong site" surgeries—surgeries that are performed on the wrong body part, such as the opposite arm or leg. After extensive planning, a statewide conference was held on steps to prevent such mistakes. This was prior to the adoption of the Surgical Checklist and dealt with specific steps, for example, on how to get the surgeon to mark the site. Surgeons could not put 'no' on the surgical site because it could be too easily misinterpreted as 'on' depending on the surgical team member's vantage point. This meeting was the first in what was to become annual meetings on different aspects of patient safety.

This inaugural conference was followed by their next conference, in partnership with CHITA: *Patient Safety and Information Technology: Software or Vaporware?*



The *My Medication List* campaign emerged to address adverse drug interactions, and to impress upon patients the importance of carrying a list of their medications at all times. As indicated in the IOM Report, medication errors and interactions are a leading cause of significant health problems and deaths. It also facilitated the sharing of best practices through the Puget Sound Safety Network.

Another WPSC project facilitated the Congestive Heart Failure (CHF) Initiative to improve the quality of patient transfer between hospitals and community providers. It also promoted the statewide adoption of a standard set of policies for any surgical procedure and setting. It also surveys hospitals to assess their use those policies and audits hospitals for compliance.

WPSC's website has also become a 'central' community resource center on patient safety related issues: <http://wapatientsafety.org/>

WPSC Funding: The Coalition is funded by membership fees based on the size and type of the organization, such as covered lives, number of beds and number of employees. WPSC generates some funding from its annual conference in the form of sponsorships and registrations. Periodically it receives some grant money, as it has the past two years for the promotion of the *My Medicine List* campaign from the Aetna Foundation and some support from the State Hospital Association for the website.

WPSC: What's Ahead?

The Coalition was quite hospital centric in its early years because hospitals were where some of the most egregious errors happened. More groups other than hospitals are now a part of the Coalition and the Coalition's areas of interest are broadening. For example, the *My Medicine List* campaign is promoted to the community as a whole.



CHITA (Community Health Information Technology Alliance)

CHITA was birthed from the CHMIS and CHIN initiatives, funded by the John A. Hartford Foundation and was the next iteration of health information technology as the internet began replacing proprietary private networks. While CHMIS and CHIN were centralized models of information sharing, CHITA was a collaborative model. CHITA helped to bridge the gap between pre-Internet CHINS/CHMIS era which had focused on building a shared *network* and the Internet era which brought a greater focus on security, data standards, and policies.

The ten founding members included the Washington State Hospital and Medical Associations; all the major health plans in the state—Regence Blue Shield, Premera Blue Cross, Group Health Cooperative—as well as Providence Health System, Swedish Hospital and Medical Center, University of Washington Medical Center, the Washington State Department of Health and Clinitech Information Resources. Their initial focus in 1996 was to address e-commerce, with a focus on both interoperability and data security. The hope was to have the CIO's (Chief Information Officers) of these organizations work collaboratively to share information securely, identify the data they could or would share, and create standards needed to enable secured data sharing.

Because of marketplace changes and the rapid growth of the Internet, CHITA evolved from that initial e-commerce focus to one that fosters public education and outreach activities to develop standards, holding quarterly conferences and creating support for special projects.

In the HealthKey project, CHITA worked collaboratively with Massachusetts Health Data Institute, the Minnesota Health Data Consortium and later added the Utah Health Information Network and the North Carolina Health Care Information Consortium with funding from the Robert Wood Johnson Foundation. The goal of that effort was to find secure ways to share information over an open Internet. Originally, it focused on administrative data such as eligibility, authorization and referrals. Benefits and clinical records were to have been added at a later date, but the Robert Wood Johnson funding ended and no replacement for that work was found.

CHITA Community Impact:

As discussed earlier, CHITA's lifetime has been marked by major technology changes, as well as major health care reform initiatives that called for data, such as HIPAA. Consequently, its path has not been linear. Despite the losses of John A. Hartford Foundation and Robert Wood Johnson Foundation funding, CHITA has managed to be flexible enough to meet changing needs during changing times while finding funding to sustain it.

Key Accomplishments:

CHITA has been able to demonstrate secure transmission of clinical data from labs to the State Department of Health and the Centers for Disease Control and Prevention, now enabling disease outbreak data to be transmitted in 2 days compared to 3 weeks. It has also developed a standard referral form for providers and payers which is still in use. It became the Strategic National Implementation Process (SNIP) for the Work Group on Electronic Data Interchange (WEDI) and staffed quarterly HIPAA readiness forums starting in 2000 to help the community prepare for the implementation of this privacy legislation

CHITA also formed the Pacific West HIPAA Congress which produced free samples of HIPAA privacy forms. The HIPAA Forums have now become CHITA Forums which provide ongoing educational programs for health care and IT in the community.

More recently, CHITA has been involved with "The Partnership for Health Improvement Through Shared Information (PHISI)." The Partnership is a health information exchange between and among the safety net providers for King County, such as the Department of Public Health, federally qualified health centers, Harborview and others. PHISI has created a governing board and has developed a business plan for both information technology and fundraising.

CHITA Funding: CHITA is funded by quarterly conference registrations, sponsorships of the CHITA Forums and grants.

What's Ahead?

"There are many prospective roles for CHITA. When it comes to health care technology collaboration in the Pacific Northwest, CHITA set the standard. Successful work across enterprises in health care must continue—especially in light of pending national health care reform. Engaging and educating the right organizations and people while responding to the ebb and flow of collaboratives and issues is something CHITA is well positioned to handle," Peter B. Summerville, Founding Director, CHITA; Principal, Rialto Communications, Seattle, WA.

Select Foundation Special Projects

Periodically, the Foundation provides a home for special projects. The first one was *QMAS* (Quality Measurement Advisory Service), funded by one of the last grants from the John A. Hartford Foundation.



QMAS

QMAS was an outgrowth of CHMIS and CHIN and the Foundation's early successes in creating risk adjusted quality standards. *QMAS* was established in 1996 to assist state and local health care coalitions in their efforts to measure health care quality for value-based purchasing and other purposes...a not for profit collaborative initiative of the Foundation for Health Care Quality, the Institute for Health Solutions and the National Coalition on Health Care. The latter two groups were

based in Washington DC. Over the course of the three years, Rick Rubin, CEO, Foundation for Health Care Quality; Dale Shaller, Executive Director, Minnesota Health Data Institute; Richard Curtis, Institute for Health Solutions, and Richard Sharpe, former program director of the Quality and Marketplace initiative, John A. Hartford Foundation, served as a resource team on how to define and collect quality measures within a given marketplace.

Their services included: Educational meetings and guides on quality measures, including consumer assessments of health plans; direct consulting services, collaborative projects, and information exchange. They worked with groups ranging from the RAND Corporation and FACCT (Foundation for Accountable Quality Measures) as well as the Joint Committee on Accreditation of Healthcare Organizations, National Center for Quality Assurance, and the Agency for Health Care Policy and Research (now Agency for Health Care Quality and Research).

QMAS held workshops, offered trainings and technical assistance. Their workshops led to a series of publications on quality: *Measuring Health Care Quality for Value Based Purchasing*, 1996; *Organizing and Financing a Health Care Quality Measurement Initiative: A Guide for Getting Started*, 1997; *Assessing Hospital Performance*, 1997; *Arm in Arm, A Guide to Implementing a Coordinated Quality Measurement Program*, 1999.

What is astonishing in reviewing these materials was the depth and breadth of the organizations involved with CHMIS and *QMAS*. What is even more astonishing is how many of these organizations are no longer here: FACCT, *QMAS*, Minnesota Health Data Institute, among many others. All the national thought leaders in the early quality movement were actively engaged with the Foundation and with the Hartford Foundation and its extensive networks. The loss of the Hartford funding was devastating to those programs. Few besides the Foundation that were nonprofits dependent on grant funding were able to survive. Also, as the market place moved away from managed care in late 90's many purchasers dropped their value purchasing initiatives, many purchasing coalitions closed their doors and others looked at other ways to influence the marketplace, such as The LeapFrog Group, or the HCPA's Employers' Health Care Purchasing Cooperative—a pool of small business owners in the hopes that pooling resources would reduce costs. The Co-op lasted beyond HCPA, but finally had to close its doors as well because even this pooled purchasing approach could not lower health care costs nor could the Co-op Board find any affordable Directors and Officers insurance for its Board of Directors.

What becomes apparent in this research is that all these marketplace, regulatory, delivery system structure and payment initiatives have not changed any of the deep incentives of the fee-for-service structure of the health care system. They also have done little to contain or lower costs.

What becomes interesting, however, is the behavior changes that emerged from the Foundation's programs. Those behavior changes have a direct bearing not only on quality, but cost as well. When behaviors change and quality improves, costs are reduced because of fewer complications, fewer errors and fewer admissions and re-admissions/re-interventions—an important lesson that should be applied to the future current reform.

The Foundation has been able to survive financially not only because of programmatic revenue streams and but also because of special projects. It has also a long-term and continuing relationship with both the Washington State Department of Health and the Health Care Authority, which have used the Foundation for a variety of studies and programs, such as the Diabetes Collaborative and the initial StORQS and COAP studies.

The Foundation's culture of a neutral, strategic and voluntary safe table offers a trusted environment for special projects where researchers have the independence to pursue work that would not be possible or trusted elsewhere. Its tradition of using good data with good information systems fosters an attractive openness for to explore ideas.

Washington Clinical Laboratory Initiative

Jon Counts, DrPH, MPH, faculty, School of Public Health and Community Medicine, University of Washington, and former Director of Public Health Laboratories in Washington and Arizona, initiated and conducted two major studies as part of the Washington Clinical Laboratory Initiative (CLI) to improve the quality and use of clinical laboratory testing.

In 1994, Counts appointed an Advisory Committee (Clinical Laboratory Advisory Committee) to provide guidance and recommendations. CLI's goal was to develop and coordinate an integrated strategic and quality improvement plan in public and private laboratories for public surveillance and patient care and safety. The key priorities were: a) create and demonstrate a new approach to develop and implement voluntary laboratory practice standards and policies; b) determine the factors that influence the delivery of medical and public health testing services; c) investigate the factors that affect adherence to voluntary laboratory practice and policy recommendations; and d) identify opportunities for improvement in the services at state public health laboratories and other referral laboratories.

One study funded by the CDC (Centers for Disease Control and Prevention), enabled Counts to implement a quality improvement project in collaboration with laboratory managers in rural critical access hospitals to identify and develop: a) criteria for the evaluation of microbiology services to be provided on-site and/or outsourced to referral laboratories; b) responsibilities for laboratory managers to monitor performance of referral laboratories; c) reporting criteria by referral laboratories; d) reports of critical laboratory values; e) reports of notifiable conditions to public health authorities; f) reports of positive cultures or preliminary test results to public health authorities; and g) recommendations by laboratory managers to improve services provided by referral laboratories.

Another study surveyed 4,500 primary care doctors and 75 infectious disease doctors (ID) to evaluate if physicians used laboratory practice guidelines developed by the State Department of Health's Clinical Laboratory Council, Centers for Disease Control and Prevention (CDC), professional medical societies, health plans and/or individual practices. Because the use of laboratory practice/testing guidelines (LPGs) is not well documented, Counts wanted to explore physician opinion on LPG use and guidelines, as well as learn their recommendations to improve awareness and usefulness of such guidelines.

Both PCP and ID specialists indicated some LPGs were helpful with patient diagnosis and selection of laboratory tests. Over 90% of the physicians who used a computerized physician order entry system (CPOE), thought integrating LPGs into their system would be useful, especially in the management of infectious diseases and clinical conditions, and if they were based on best applicability to the patient population and clinical needs. They also thought LPGs should be reviewed and endorsed by institutional stakeholders, such as a hospital medical advisory committee.

Information technology offers a significant opportunity to assist physicians in selecting diagnostic tests, interpreting results, and reducing patient errors by integrating LPGs with clinical practice guidelines or as a separate guideline in electronic decision support systems. Additionally, it would reduce practice variations among practitioners and optimize the potential of having additional time for patient management, but the challenge is the time and cost of integrating LPGs into existing systems or the purchase of new ones. Findings from these studies will be published when complete on the Foundation's website.

Additional information on LPGs can be found on the Washington State Medical Association's website: www.wsma.org/memresources/reference6.html#clac and at the Department of Health www.doh.wa.gov/hsqa/fsl/lqa_practice_guidelines.htm

Washington State Department of Health and The Diabetes Collaborative

Diabetes is a serious, common and costly disease, yet it is controllable and for type 2 diabetes preventable. Because of the high prevalence of the disease, the Department of Health wanted to develop some best practices guidelines that result in the best outcomes (year?). With funding from the Department of Health, CDC and PhRMA (Pharmaceutical Researchers and Manufacturers Association), DOH worked with the Foundation to develop a program to support participation in a series of yearlong collaborative educational endeavors. The Foundation offered the independent neutral home to award and distribute scholarship funds that enabled physicians from largely small, rural clinical practices to participate in these programs.

Ann Kelley, then Quality Improvement Program Manager at the Foundation worked with the Department of Health to develop the criteria to select the grant recipients, selected the participants, and evaluated the program. Additionally, training materials were prepared to help the clinics understand the best practices, as well as how they could change their clinical operations to provide better care. These included criteria for frequency of patient visits and foot care among others. They also tried to identify barriers to providing optimal care.

With some additional funding from PhRMA, the collaborative offered the "Booster Shot" program which was designed to address "just one thing that would get a clinic over the hump" to provide optimal care. Sometimes it was something as simple as purchasing a color printer so the clinic could read the black, red and green codes for population measures, or take a group of patients with diabetes to the grocery store to select diabetes friendly food, then prepare some samples meals in a cooking class. Care and treatment guidelines were compiled into a diabetes tool kit for patients and providers, which were distributed to Collaborative participant clinics. <http://www.wapatientssafety.org/downloads/GHC-Plain-Language-Toolkit.pdf>



Outbreak Detection Information Network

Outbreak Detection Information Network (ODIN)

Peter Dunbar, MD, ChB, MBA, served as principal investigator for the ODIN Study, funded by a 2.5 million grant from the Department of Defense (DOD) to develop an electronic infectious disease tracking system in the Northwest. It was designed to use the emerging

syndromic surveillance science to capture data from health encounters to predict disease outbreaks ahead of clinically verified laboratory results. A major goal was to yield a product that would have extensive functionality for the public health departments to use and to provide a longer term toolset for other epidemiology projects.

The project also focused on improving the safety of civilian and military populations by improving the accuracy, timeliness, communication and analysis and interpretation of novel sources of health-related data. Such a system would provide surveillance that supports rapid intervention of biologic threats to the military and civilian populations. Potential bioterrorism threats as well as adverse health events from natural causes, created a need for rapid and effective detection and response. The Foundation collaborated with the DOD and local public health departments (local health jurisdictions) to: create minimum standards for health indicator data collection in Puget Sound region; adopt techniques to improve interpretation of collected health indicator data; and improve techniques and capability to respond to and communicate with appropriate communities regarding surveillance findings.

VI. A Pivotal Point: Lessons Learned, Challenges and Opportunities

That the Foundation has maintained core funding and continues to offer a 'safe table' to discuss and study new clinical issues is a tribute to the Foundation's leadership and culture. That it has sustained an existence is a tribute to program director, CEO and Board tenacity and commitment. As the nation lurches into the actual implementation of 2010 health care reform, the Foundation's history offers many lessons, probably one of the most important of which is—good information and good data change behavior.

"I think the Foundation's value is that every time there is a new initiative or program, the Foundation offers a venue where people who don't normally trust each other actually want to work together," said Miriam Marcus-Smith, Program Director, WPSC. "I think the Foundation has demonstrated individually and collectively that diverse groups—given the right environment—can work together on important goals. These are real impacts for real people—this is not theoretical work."

Good information and good data are most readily trusted, however, when that information comes from peer to peer physician-driven research. It is interesting that the initial Philosophy of the Foundation made the explicit point that "*Voluntary, cooperative efforts....[are] more effective than, and preferable to, government intervention through prescribed regulatory standards.*" The challenge for reform is: could such a voluntary approach move fast enough or be broad enough?

It is notable how the first COAP study played out. The Centers of Excellence approach for cardiac surgery was to have been a regulatory, legislative one, as had happened in New York. Instead, physicians under the auspices of a nonprofit, neutral foundation, collaborated with a public agency and achieved mutually acceptable results. A physician-driven effort was made possible by a simple contractual clause; thereby meeting the physicians' need for autonomy and the State's need for standards and control.

What also is clear from writing this history, is that the myriad approaches to control health care costs—from purchasing for value, to managed care to RBRVSs to DRGs ad nauseam—have had no impact on controlling costs. What stands out in writing this is that costs are reduced when variations in care are reduced.

What is not clear is what cost savings would transpire over time and if the savings would be one time after the first savings emerged from reduced variations and improved quality. Also unknown is if this approach would create a new learning culture that fosters even greater opportunities for improvement in the future. It is the hope and expectation of the Foundation that both continued savings and learning would occur.

Challenges

Like funds for any nonprofit agency, funding revenues wax and wane as Foundations and government agencies reexamine their priorities and budgets. This was written mid-2010 as state funds to support early innovations in the past will probably decline as state revenues erode. However, with the passage of health care reform legislation in March 2010, more emphasis has been placed on comparative outcomes research, the implementation of Electronic Medical Records and meaningful use, which may offset those losses.

Opportunities

The Foundation has not been highly visible to the public at large. As the Patient Safety Coalition continues its work with more public campaigns, such as *My Medicine List*, more of the Foundation's activities will come to public attention. The Surgical Checklist also provided some important visibility for the Foundation and its programs. Indeed, the 2010 study by the American College of Obstetrics and Gynecology reflects the importance of such checklists and systems approach to surgical care, which and is an issue near and dear to every patient about to face surgery. The newsletters of the Foundation programs will continue to report on the Foundation's activities and attract new clinicians.

COAP and SCOAP's ability to benchmark processes means almost any clinical procedure can be studied and refined, which greatly expands the Foundation's ability to work with a broad range of the provider community. A pilot study in the field of obstetrics (OB COAP) is currently underway and other medical specialties are showing increasing interest in the Foundation's work.

With the passage of Affordable Health Care Act of 2010, the Foundation and its programs have the very real opportunity to be a national resource. COAP and SCOAP offered the clinical models, the success of the Surgical Checklist and the creation of benchmarks to measure clinical processes and procedures offer genuinely useful tools that are of measurable use. They also generate systems savings and improved patient outcomes.

The Foundation's history and successes can now serve as a road map and template for other programs across the country, and could be of special use by the Surgeon General, Health and Human Services and medical societies, among others. The road map the Foundation offers is one of collaboration, respect and actions that can improve quality and lower cost. Better quality means lower costs, as SCOAP has so clearly demonstrated.

As the push for EMRs accelerates, the Foundation's neutral, safe haven reputation has put it once again at the forefront of developing standards and guidelines for sharing health care information. It has also brought the Foundation almost full circle with its early origins. OneHealthPort, headed by Rick Rubin, former Foundation CEO, was selected by the Health Care Authority to be the lead agency to create a statewide capability to share sensitive health care information.

The Foundation was selected to be the oversight agency for this undertaking on behalf of the community to assure the work is appropriate and fairly priced.

Lessons Learned for the Road Ahead

The keys to the Foundation's success have been the commitment and passion of the participating physicians and Foundation staff and its culture of collaboration and trust. The Foundation provides a respected 'safe table' where researchers can explore variations in care in a non-punitive environment and learn from each other—a rare feature in health care. Many groups have all the stakeholders at the table, but many of those stakeholders are not there willingly or participate only there to block anticipated adverse courses of action to them.

The Foundation continues to attract new programs and research. It is a wealth of information for an industry desperately seeking answers. Its programs and methodologies provide templates which can be replicated in other states and nationally.

Conclusion

The Foundation's work has led to better care processes because it offers the ability to get the data back to the people who make care decisions: the physicians, surgeons and quality experts who provide that care. It engages physicians so they have a better understanding of what they do and how to provide care that has the best outcomes.

The Foundation's work has now led to asking the most important question: Should we do this procedure at all? The Foundation's work also demonstrates what a non-regulatory, collaborative approach and a learning culture can accomplish.

"The Foundation provides an important platform for business, physicians and patients, reduces the sometimes stark variations in care, and works with hospitals and physicians to reduce that variation by the development of colleague-driven best practices. With an estimated savings of \$3-4 million per year from one procedure alone—colorectal surgery—the Foundation's work clearly demonstrates we can have savings from a collaborative, participatory learning community. We have shortened length of stay, improved the quality of care, and reduced complications and re-interventions, which is a huge benefit to the patient. We have also saved the system millions of dollars at the same time," Terry Rogers, MD, CEO, Foundation for Health Care Quality.

These are important lessons. We can only hope they will be heeded and learned.

Acknowledgements

This history was made possible by the voluntary cooperation of many people. A complete list of those interviewed appears in Appendix One. We would especially like to thank The John A. Hartford Foundation, Inc. for sharing with us its complete list of grants in its Marketplace and Quality Initiative. This information was instrumental in re-creating the early years of the Foundation. We would also like to thank the early founders, board members and program directors in re-living the early history of the Foundation as they experienced it. We are deeply grateful to Kathleen O'Connor for her research and writing which has revitalized the important work of the Foundation, and to tie it to the sweep of health care reform. Thanks are also in order for Nelly Gozdek, MPH, MHA, for her copyediting and formatting of the final report. Special thanks are in order for Michael Taylor-Judd, Administrative Manager, for his success in tracking down reports and people, which has led to the success of this history.

Thanks to all the program directors, principal investigators, Board and staff members who have made the Foundation not only a safe haven, but the incubator of studies that would not otherwise have happened. This history is a tribute to their vision and passion, without which the Foundation would not have been possible.

Terry Rogers, MD, CEO, Foundation for Health Care Quality, October 2010

Appendix One: List of Participant Interviews

Note: Considerable holes exist over the past 20 years, so it is not possible to accurately list the dates which these people worked at the Foundation. For this reason dates were omitted for all those interviewed.

David Bjornson, retired, Chairman, Board of Directors, FHCQ. He was the second Chairman of the Board.

Chris Bryson, MD, MS, current Medical Director, COAP; Investigator, VA Health Services Research and Development; Assistant Professor, Division of Internal Medicine, University of Washington.

Andrea Castell, RN, MBA, former Executive Director, Health Care Purchasers' Association.

Jon M. Counts, DrPH, MPH, Principal Investigator, CLI.

Tom Curry, Executive Director, Washington State Hospital Association; Founding Board Member, FHCQ; current Board Member, FHCQ.

Francisco J. Doll, current Grants Manager, The John A. Hartford Foundation, Inc.

Peter Dunbar, MD, ChB, MBA, former Chair, Board of Directors, FHCQ; Professor, Anesthesiology, University of Washington.

Andy Fallat, former CEO, FHCQ.

David Flum, MD, MPH, current Medical Director, SCOAP; Professor of Surgery and Health Services, University of Washington.

Richard Goss, MD, Medical Director and Director, of Quality Improvement, Harborview Medical Center and founding Medical Director, COAP.

Leo Greenawalt, CEO, Washington State Hospital Association; Founding Board Member, FHCQ.

Lance Heineccius, former policy director, Washington State Health Services Commission, and Project Consultant, severity project.

Rosa Johnson, current Program Director, SCOAP.

Ann Kelley, Quality Improvement Program Manager, FHCQ.

Steve Leahy, former Executive Director, Greater Seattle Chamber of Commerce; and Chamber staff representative on Chamber Health Care Committee, which became HCPA.

Linda Lekness, current Program Director, CHITA.

James LoGerfo, MD, MPH, FACP, Adjunct Professor, Global Health and Health Service, School of Medicine, University of Washington; Principal Investigator, StORQS.

Keith McCandless, currently co-Founder, Social Inventions Group; Interim Executive Director, FHCQ.

Miriam Marcus-Smith, current Program Director, Washington Patient Safety Coalition and former program director, COAP.

Joe Nichols, MD, Founding Member Board of Directors, FHCQ; Principal, Health Data Consulting.

Phil Nudelman, CEO Emeritus, Group Health Cooperative of Puget Sound; Founding Chairman of the Board, FHCQ.

Laura Ripp, former Program Director, Community Health Information Partnerships; currently, President, RPM Services, Inc., New Jersey.

Terry Rogers, MD, current CEO, Foundation for Health Care Quality; former board member.

Rick Rubin, CEO, OneHealthPort; President and Co-Founder, EconoMedrics, consultant to Health Care Purchasers' Association; former CEO, FHCQ.

M. Lynn Ryder, Executive Vice President Emeritus, Washington Mutual Bank; Founding Board Member, Health Care Purchasers' Association.

Dale Shaller, former Executive Director, Minnesota Health Data Institute, Consultant, QMAS; current, Principal, Shaller Consulting.

Richard Sharpe, retired, former Executive Vice President, Donald W. Reynolds Foundation; and former Program Director, Marketplace and Quality Initiative, The John A. Hartford Foundation, Inc.

Kristin Sitcov, current Program Director, COAP.

Peter B. Summerville, First Executive Director, CHITA; current Principal, Rialto Communications.

Dorothy Teeter, COO, Seattle-King County Department of Public Health; former Interim CEO, FHCQ.

Elizabeth Ward, Chief of Inpatient Services, Navos; former CEO, FHCQ; former Director, CHITA.

Appendix Two: List of Publications

Note: This list consists of two parts: 1) Reports and white papers produced by the Foundation; and 2) journal articles of the Principal Investigators (PI) which have appeared in professional journals. It does not include newspaper or other articles about the Foundation and its programs. Publications are listed in Chronological order, beginning with the earliest and leading to the present.

Interpreting Severity Adjusted Quality Indicators: Lynette Jones, MS, MHA, Project Director; Sigrid Schreiner, MHA, Project Analyst; James LoGerfo, MD, MPH, Principal Investigator; Forward by Keith McCandless, May 1989. Funded by a grant from The John A. Hartford Foundation, Inc.

StORQS (Statewide Obstetrics Review and Quality System) Project: Summary of the Final Report to the Foundation for Health Care Quality, James LoGerfo, MD, MPH, Principal Investigator. Study in conjunction with University of Washington's Health of the Public Program, August 1992. Funded with a grant from the John A. Hartford Foundation, Inc.

Privacy and Health Information Systems: A Guide to Protecting Patient Confidentiality: Janlori Goldman and Deirdre Mulligan, Center for Democracy and Technology, Washington DC; in conjunction with the Foundation for Health Care Quality and Severyn Health Care Consulting, Fairfax, VA, 1996. Funded with a grant from the John A. Hartford Foundation, Inc.

Measuring Health Care Quality for Value-Based Purchasing: A Report on the proceedings of an educational meeting sponsored by the Quality Measurement Advisory Service (QMAS), Written and Produced by Severyn Healthcare Consulting & Publishing, Fairfax, VA. 1996. Funded from a grant from the John A. Hartford Foundation, Inc.

Organizing and Financing a Health Care Quality Measurement Initiative: A Guide for Getting Started; QMAS, in conjunction with National Business Coalition on Health, Washington, DC, Institute for Health Policy Solutions, Washington DC, and Foundation for Health Care Quality, Seattle, WA. Written and Produced by: The Severyn Group, Inc., Fairfax, VA. 1997. Funded with a grant from the John A. Hartford Foundation, Inc.

Assessing Hospital Performance, QMAS, Written and Produced by The Severyn Group, Inc., 1997. Funded with a grant from the John A. Hartford Foundation, Inc.

Keys to a Healthy Partnership: A Guide through the ups and downs of collaboration, Richard Rubin, Foundation for Health Care Quality and Lise Rybowski, The Severyn Group, 1998. Funded with a grant from the John A. Hartford Foundation, Inc.

Building an Infrastructure for Community Health Information: Lessons from the Frontier, Lise Rybowski, The Severyn Group, Inc. and Richard Rubin, Foundation for Health Care Quality, 1998. Funded with a grant from the John A. Hartford Foundation, Inc.

Arm in Arm: A Guide to Implementing a Coordinated Quality Measurement Program, QMAS, in collaboration with Westat and distributed in partnership with: Academy of Consumer-Choice Health Purchasing Groups, Institute for Health Policy Solutions, Washington DC; National Association of Health Data Organizations, Salt Lake City, UT and the National Business Coalition on Health Care, Washington DC, 1999. Funded with a grant from the John A. Hartford Foundation, Inc.

The HealthKey Program, Phase One Reports: PKI in Healthcare: Recommendations and Guidelines for Community-Based Testing and A Framework and Structured Process for Developing Responsible Privacy Practices, funded with a grant from the Robert Wood Johnson Foundation, May 15, 2000.

The National HealthKey Collaborative: Securing the Exchange and Use of Electronic Health Information to Improve the Nation's Health: A Summary Report to the Community, in partnership with: HealthKey,

Massachusetts; Health Key Minnesota; Health Key North Carolina; HealthKey Utah; HealthKey Washington; HealthKey Program Administration, funded with a grant from The Robert Wood Johnson Foundation, 2001. *ODIN: Outbreak Detection Information Network: Scope Document*, with PALADIN Data Systems Corporation, 2004. Funded with a grant from the Department of Defense, 2004.

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Parrish K, Holt V, Connell F, Williams B, LoGerfo JP: *Validation of birth certificate and hospital discharge data in Washington State*. *Am J of Epidemiology*, 1992; 1013-1014.

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Goss, J. Richard. *Practical Case Studies in CABG CQI*. AHA 2nd Scientific Forum on Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke. Washington D.C., April, 2000.

Johnston, GG, Malmgren J, Goss JR. *Can patients tell us how long they will be in the hospital?* American College of Cardiology National Meeting, Atlanta GA, March 2001.

SCOAP: Peer Reviewed Publications

Flum D, Fisher N, Thompson J, Marcus-Smith, M, Florence M, Pellegrini C. *Washington State's approach to variability in surgical processes/outcomes: Surgical Clinical Outcomes Assessment Program (SCOAP)*. Surgery, 138:5, 821-828.

Clinical Laboratories: Peer Reviewed Publications

Counts J, Astles J, Tenover F, Hindler J, *Systems Approach to Improving Antimicrobial Susceptibility Testing in Clinical Laboratories in the United States*, Journal of Clinical Microbiology, July 2007, 2230-2234.

Appendix Three: Board of Directors and CEOs 1988-2010

Some gaps exist in the Foundation's history. The following reflects information available to us. We have included titles, when we had the information. We regret any omission or errors in the following list:

Board of Directors:

1988: Founding Board of Directors and 1989 Board

Phil Nudelman, *Chairman, Executive Vice President, Group Health Cooperative*

John Bencich, *Associate Executive Director, Swedish Hospital Medical Center*

David Bjornson, *Administrator, St. Peter Hospital, Olympia*

Nancy Cannon, *Manager, Employee Benefits, Boeing*

Andrea Castell, RN, BSN, MBA, *Health Care Purchasers' Association*

Mark Chassin, MD, MPP, MPH, *Senior Vice President, Value Health Sciences, Santa Monica, CA*

Jeffery B. Clode, MD, *Internal Medicine, Spokane*

Tom Curry, *Executive Director, Washington State Medical Association*

V. Mark Droppert, *Vice President, Human Resources, Paccar*

Monte DuVal, MD, *Senior Vice President of Medical Affairs, Samaritan Health Services, Phoenix, AZ*

Leo Greenawalt, *President, Washington State Hospital Association*

Keith McCandless, *Interim Executive Director, Foundation for Health Care Quality*

Jim Nell, *President, Seattle Area Hospital Council*

Joseph Nichols, MD, *orthopedic surgeon, Tacoma*

Richard Rubin, *Executive Vice President, EconoMedrics*

A.H. "Bud" Towsey, *Executive Vice President, First Interstate Bank*

Michael Wilson, *Vice President, Ambulatory Services, Sacred Heart Medical Center, Spokane*

1990

Dave Bjornson, *Chair*

John Bencich, MD

Nancy Cannon

Andrea Castell

Jeffrey Clode, MD

Tom Curry

V. Marc Droppert

Leo Greenawalt

Brian Heinrich, MD

James LoGerfo, MD, *Director, Robert Wood Johnson Foundation Clinical Scholars, University of Washington*

Keith McCandless

Jim Nell

Joseph Nichols, MD

Phil Nudelman

Rick Rubin

Cynthia Sonstelie

Michael Wilson

1991

Dave Bjornson, *Chair*

John Bencich MD

Nancy Cannon

Andrea Castell

Jeffrey Clode, MD

Robert Crittenden, MD, *Executive Policy Office, Governor's Office, Washington State*

Tom Curry

V. Marc Droppert

Leo Greenawalt

Brian Heinrich, MD

James LoGerfo, MD, *Director, Robert Wood Johnson Foundation Clinical Scholars, University of Washington*

Keith McCandless

Jim Nell

Joseph Nichols, MD

Phil Nudelman

Rick Rubin

Cynthia Sonstelie

Michael Wilson

1992

David Bjornson, *Chair*

John Bencich, MD

Nancy Cannon

Andrea Castell

Mark Chassin,

Jeffery Clode, MD

Robert Crittenden, MD

Tom Curry

Nancy Dapper, *Regional Administrator, Health Care Financing Administration, Region X*

V. Marc Droppert

Kristine Gebbie, *Secretary, Washington State Department of Health*

Leo Greenawalt

James LoGerfo, MD

Jim Nell

Joseph Nichols, MD

Phil Nudelman

Don Sacco, *CEO, Pierce County Medical Association*

Cynthia Sonsteli
Michael Wilson

1993

David Bjornson, *Chair*
Tom Byron, *Washington State Hospital Association*
Andrea Castell
Tom Curry
Nancy Dapper
V. Marc Droppert
Brian Goddell, MD, *Executive Director, Swedish Hospital Medical Center*
Irwin Goverman, *Vice President and CIO, Group Health Cooperative*
Leo Greenawalt
Beverly Jacobson, *Seattle Area Hospital Council*
James LoGerfo, MD
Bruce Miyahara, MD, *Secretary, Washington State Department of Health*
Jim Nell
Joseph Nichols, MD
Phil Nudelman
Linda Parker
Rick Rubin
Don Sacco
George Schneider MD, *Spokane*
Elizabeth Ward, *Assistant Secretary, Washington State Department of Health*
Steve Welsh, *Vice President, Todd Shipyards*

1994-1995 *incomplete

This list includes the board members from 1993, who presumably served part of the time in 1994 and 1995. Complete records resume in 1996.

David Bjornson, *Chair*
Tom Byron
Andrea Castell
Tom Curry
Nancy Dapper
V. Marc Droppert
Brian Goddell, MD
Irwin Goverman
Leo Greenawalt
Beverly Jacobson
James LoGerfo, MD
Bruce Miyahara, MD
Jim Nell
Joseph Nichols, MD
Phil Nudelman
Linda Parker
Rick Rubin
Don Sacco

George Schneider MD,
Elizabeth Ward
Steve Welsh

1996

William M. Dean, MD, *Chair, Urologist, Tacoma*
David Bjornson, *immediate past chair*
Gary Christenson, *Administrator, Health Care Authority*
Nancy Dapper
Richard Deyo, MD
V. Marc Droppert
Andrew Fallat, FACHE, *CEO, Evergreen Hospital*
Irwin Goverman
Bruce Miyahara, MD
Joseph Nichols, MD
Terry Rogers, MD, *Executive Vice President and COO, King County Medical Blue Shield*
Steve Welsh

1997

William M. Dean, MD, *Chair, Urologist, Tacoma*
David Bjornson
Gary Christenson
Nancy Dapper
Richard Deyo, MD
V. Marc Droppert
Peter Dunbar, MD, *Anesthesiologist, Harborview Medical Center*
Andrew Fallat
Irwin Goverman
Bruce Miyahara, MD
Terry Rogers, MD
Steve Welsh

1998

William Dean, *Chair*
David Bjornson
Gary Christenson
Nancy Dapper/Linda Ruiz, *Regional Administrator, Health Care Financing Administration*
Richard Deyo, MD
Marc Droppert
Peter Dunbar, MD, *Department of Anesthesiology, Harborview Medical Center, University of Washington*
Andy Fallat
Irwin Goverman
Tanis Marsh, *Health Care Director, League of Women Voters*
Bruce Miyahara/ Mary Selecky, *Secretary, Department of Health*
Terry Rogers, MD

Dorothy Teeter, *Vice President, Quality and System Resources, Group Health Cooperative*
Steve Welch

1999

William Dean, *Chair*
David Bjornson
Gary Christenson
Jac Davies
Richard Deyo, MD
Peter Dunbar, MD
V. Marc Droppert
Andrew Fallat
Irwin Goverman
Tanis Marsh
Terry Rogers, MD
Linda Ruiz
Elizabeth Ward, *Assistant Secretary, Department of Health*

2000

Peter Dunbar, MD, *Chair*
David Bjornson
Richard Deyo, MD
Andrew Fallat
Irwin Goverman
Tanis Marsh
Terry Rogers, MD
Linda Ruiz
Dorothy Teeter
Mary Selecky

2001

Peter Dunbar, MD, *Chair*
Mark Adams, MD, *Thoracic and Vascular Surgeon*
David Bjornson
Deb Cablao, *Director of Marketing, Intel Internet Health Division, Beaverton, Oregon*
Richard Deyo, MD
Andrew Fallat
Tanis Marsh
Jeff Robertson, MD, *Vice President, Health Care Services, Regence Blue Shield*
Terry Rogers, MD
Linda Ruiz
Mary Selecky (represented by Jac Davies, *IRM/ Assessment Coordinator, Department of Health*)
Dorothy Teeter

2002

Peter Dunbar, MD, *Chair*
Mark Adams, MD, *Thoracic and Vascular Surgeon*
David Bjornson

Deb Cablao
Richard Deyo, MD (represented by Daniel Lessler, MD, *Associate Medical Director, Harborview Medical Center during Deyo sabbatical*)
Andrew Fallat
Tanis Marsh
Jeff Robertson, MD
Terry Rogers, MD
Linda Ruiz
Mary Selecky (represented by Jac Davies)
Dorothy Teeter

2003

Peter Dunbar, MD, *Chair*
Mark Adams, MD
David Bjornson
Deb Cablao
Jac Davies, *Director, Program Development, Inland Northwest Health Services, Spokane*
Victor Dirksen, *Administrator, Jefferson General Hospital, Port Townsend*
Andrew Fallat
Jeffery Gingold, JD, *Attorney, Lane Powell Spears Lubersky*
Daniel Lessler, MD
Tanis Marsh
Jeff Robertson, MD
Terry Rogers, MD
Linda Ruiz
Melvin Sorensen, *Principal, Carney Bradley Spellman*
Dorothy Teeter
Jude Van Buren, DrPh, MPH, RN, RS, *Washington State Department of Health*
*Christine L. Rubadue, ND, MN, RN, *Associate Regional Administrator, Health Care Financing Administration, Centers for Medicare and Medicaid Services (non-voting board liaison)*

2004

Dorothy Teeter, *Chair*
David Bjornson
Deb Cablao
Jac Davies
Victor Dirksen
Jeffery Gingol, JD
Daniel Lessler, MD
Tanis Marsh
Jeff Robertson, MD
Terry Rogers, MD
Melvin Sorensen
Jude Van Buren
*Christine L. Rubadue

2005

Dorothy Teeter, *Chair*
 David Bjornson
 Deb Cablao
 Jac Davies
 Jeffery Gingold, JD
 Daniel Lessler, MD
 Tanis Marsh
 Jeff Robertson, MD
 Terry Rogers, MD
 Melvin Sorensen
 Jude Van Buren
 *Christine L. Rubadue

2006

Dorothy Teeter, *Chair*
 Deb Cablao
 Michael Cochran, *First Vice President, Health and Wellness Benefits, Washington Mutual Bank*
 Jac Davies
 Jeffery Gingold, JD
 Mike Glenn, *Administrator, Olympic Medical Center, Port Angeles*
 Daniel Lessler, MD
 Tanis Marsh
 Jeff Robertson, MD
 Terry Rogers, MD
 Melvin Sorensen
 Jude Van Buren
 *Kenneth S. Fink, MD, *CMS, Region X (non-voting board liaison)*

2007

Terry Rogers, MD, *Chair*
 Deb Cablao
 Michael Cochran
 Jac Davies
 David Dreis, MD, *Medical Director of Clinical Outcomes, Virginia Mason Medical Center*
 Jeffery Gingold, JD
 Mike Glenn
 Daniel Lessler, MD
 Tanis Marsh
 Jeff Robertson, MD
 Melvin Sorensen
 Jude Van Buren
 *Kenneth S. Fink, MD

2008

Jeffery Gingold, JD, *Chair*
 Deb Cablao
 Michael Cochran

Marina Cofer-Wildsmith, *former CEO, American Lung Association of Washington*
 Jac Davies
 David Dreis, MD, *Medical Director of Clinical Outcomes, Virginia Mason Medical Center*
 Mike Glenn
 Daniel Lessler, MD
 Tanis Marsh
 Patti Rathbun, *Health Policy Coordinator, Office of Legislative and Constituent Relations, Dept. of Health*
 Jeff Robertson, MD
 Melvin Sorensen
 *Kenneth S. Fink, MD

2009

Jeff Gingold, JD, *Chair*
 Marina Cofer-Wildsmith
 Tom Curry, *Executive Director, Washington State Medical Association*
 Debbie Dexter
 David Dreis, MD
 Joe Gifford, MD
 Tanis Marsh
 Patti Rathbun
 Jeff Robertson, MD
 Melvin Sorensen
 Hugh L. Straley, MD, *Medical Director, Puget Sound Health Partners*
 *Kenneth S. Fink, MD

2010

Jeff Gingold, JD, *Chair*
 Marina Cofer-Wildsmith
 Debbie Dexter
 David Dreis, MD
 Joe Gifford, MD, *Chief Medical Officer, Regence Blue Shield*
 Tanis Marsh
 Patti Rathbun
 Melvin Sorensen

Foundation CEOs:

Keith McCandless, Acting Executive Director, In-kind Contribution, Washington State Hospital Association	1989-1992
David Friedman	1992-1993
Rick Rubin	1993-1999
Elizabeth Ward, RN, MN	1999-2001
Dorothy Teeter, MHA	2001-2002
Andrew Fallat, FACHE	2002-2008
Terry Rogers, MD	2008-