



**ADDRESSING CHRONIC CONDITIONS
THROUGH COMMUNITY PARTNERSHIPS:
A FORMATIVE EVALUATION OF TAKING ON DIABETES**

Susan E. Palsbo, Thilo Kroll, and Melissa McNeil

National Rehabilitation Hospital Center for Health & Disability Research

FIELD REPORT

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ABSTRACT: Community partnerships—coalitions of health plans, physicians, and local groups—can help overcome organizational boundaries and allow competing parties to work together to focus on a shared goal, like the treatment of a chronic condition. In this study, researchers evaluated three community partnership projects sponsored by a national trade association of health plans. These initiatives, focused on quality improvement in diabetes care, were located in three very different markets in the United States: Albuquerque, New Mexico; Kansas City, Missouri; and Westchester County, New York. Successful community partnerships, the researchers found, can be formed from different starting points and by following different paths. Instead of following a strict set of protocols, the researchers suggest that these groups pay careful attention to principles of group dynamic theory. In addition, a neutral facilitator, like a trade association, can build bridges and help competing concerns be less proprietary.

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ABOUT THE AUTHORS

Susan E. Palsbo, Ph.D., M.S., is senior research associate at the National Rehabilitation Hospital Center for Health & Disability Research. Her areas of study include care coordination for people with physical disabilities and telerehabilitation. She received her M.S. and Ph.D. in health services research from George Washington University.

Thilo Kroll, Ph.D., is a senior research associate at the National Rehabilitation Hospital Center for Health & Disability Research. His areas of study include behavioral change and health psychology of children and adults with physical disabilities. He received his Ph.D. in health psychology from the University of Bremen.

Melissa McNeil, M.S., M.S.W., is a former research analyst at National Rehabilitation Hospital Center for Health & Disability Research. She received her M.S. from the University of South Alabama, and her M.S.W. from the University of Alabama.

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EXECUTIVE SUMMARY

There is growing interest in community-wide, evidence-based quality improvement for chronic conditions. America's Health Insurance Plans (AHIP), a national trade association of health plans that is the result of the merger between the American Association of Health Plans and the Health Insurance Association of America, is sponsoring several initiatives to form community partnerships of health plans, physicians, and local quality improvement organizations. This novel, collaborative approach targets such chronic diseases as diabetes, asthma, and cardiovascular disease by coordinating and combining the efforts of individual health plans within a single market.

This field report presents findings of a formative program evaluation funded by The Commonwealth Fund in 2002. The evaluation identified key attributes that led to the successful formation of Taking on Diabetes (TOD), AHIP's community partnerships in Albuquerque, New Mexico; Kansas City, Missouri; and Westchester County, New York. It sought to answer the following questions:

- What elements and forces are necessary to bring together competing organizations?
- What is necessary to sustain these community partnerships?
- What recommendations can be made to replicate this approach for other chronic conditions and in other communities?
- To what extent do local market characteristics and structures set the direction of community partnerships and influence success?

INTERVIEWS, MARKET ANALYSIS, AND SITE VISITS

The authors conducted two dozen semi-structured interviews, gathered comprehensive information on the medical and insurance market at the three sites, and observed meetings of the community partnerships at two sites. In preparation for the interview guides and the subsequent data analysis, the authors conducted a thorough review of the literature on group dynamics and health care partnerships. They identified 50 attributes thought necessary for successful establishment and sustainability of groups and community health partnerships. The authors grouped these attributes into the following eight domains: governance/accountability, nature of the problem being addressed, composition, differentiation, coordination and integration, centrality, alignment, and market structure. The semi-structured interviews covered each domain. The authors measured the strength of agreement for each attribute as reported by the participants, and paired the attributes with the community partnership outcome at each site.

This report's primary finding is that competing health plans and local organizations can establish and sustain viable partnerships around a shared goal. This successful outcome may be reached by following different paths, starting from different origins, and operating in different environments. A nascent community partnership does not need to meet a set of hard criteria, be located in a particular type of market, or follow a particular protocol. Rather, sponsors of community partnerships must pay careful attention to principles of group dynamic theory, such as fostering a sense of belonging to the group, sharing information and plans, and aligning individual goals with group goals.

The authors also found that each partnership site has unique characteristics, some of which directly affect the prevalence of diabetes and the operational logistics of the interventions. Albuquerque, New Mexico, is a consolidated health plan market, composed of four health plans ranging in size from about 9,000 members to over 181,000 members. An integrated delivery network owns the dominant health plan; no new plans have started in over 10 years. It has the highest health plan penetration of the three communities. The Albuquerque area has a comparatively low population density. Over 40 percent of the population is uninsured or on Medicaid. Of the three sites, Albuquerque is the community with the lowest per capita income and the highest poverty rate. Around 20 percent of its population is Latino and 4 percent is Native American.

The Kansas City, Missouri, market is the most active of the three sites. HMOs and PPOs combined have about 90 percent of the private-sector market. However, enrollment is fragmented across 18 plans, with no dominant player. There is a great deal of churning, with several new start-ups in the past two years, as well as some dramatic departures. Kansas City is not as wealthy as Westchester nor as well educated as either Albuquerque or Westchester but has a greater percentage of people with jobs and public or private insurance than does Albuquerque. About 20 percent of its population is African American.

The stability of the health plan market in Westchester County, part of the New York metropolitan area, is between that of Albuquerque and Kansas City. Three-quarters of its HMO market is divided nearly evenly across three long-established health plans, with the remainder of the market composed of 15 much smaller health plans. Despite their long-standing availability in the area, health plans have only a 32 percent penetration of the insured market, and 40 percent of the private market. Westchester is an affluent community. Over one-third of the population has a college degree, and the median household income is 1.5 times that of Albuquerque. Around 15 percent of the population is African American, 10 percent is Latino.

The HMO and PPO personnel at each site were very interested in forming community-wide partnerships to address diabetes. But this shared interest did not mean that AHIP could develop a simple recipe for success. The table shows how AHIP played different roles according to the organizational dynamics and background of each community.

Table ES-1. Selected Features of the Three Sites

	Albuquerque, N.M.	Westchester County, N.Y.	Kansas City, Mo.
Group origin	TOD formed it	Already formed	Weakly formed
Role of AHIP	Catalyst; initial leadership	Recruited as outside expert, particularly to sustain local efforts	Recruited as matchmaker; later navigated midcourse correction
Initial project	Common guidelines	Common guidelines	BTS for selected doctors
Financing (staff and in-kind contributions)	Combination of state, PRO, TOD	N.Y. State HMO Association; some state; TOD	Local foundation funding; TOD support of BTS

Notes. BTS, Breakthrough Series; TOD, Taking on Diabetes, PRO, Peer Review Organizations

GROUP DYNAMICS MORE IMPORTANT THAN MARKET CHARACTERISTICS IN FORMING PARTNERSHIPS

The authors took a different approach from most prior studies of community health partnership formation. Instead of focusing primarily on market structure, they interviewed the participants to delve into the organizational characteristics that led to successful group formation. The authors found that market characteristics play relatively minor roles in dictating whether partnerships will be established and sustained. Market characteristics do influence the success of partnership initiatives.

RECOMMENDATIONS

This field report suggests that competing health plans, physicians, and other health care organizations can successfully establish and sustain community partnerships. The authors believe that careful attention to organizational and group dynamics can result in successful partnerships, regardless of the market structure. Although more research needs to be done using different programs and among different communities, the partnership participants and the authors have several recommendations that should increase the likelihood of fostering successful initiatives. These recommendations are as follows:

Establishing the Partnership

- Identify an unbiased facilitator.
- Identify an active coordinator.
- Recruit at least one strong local champion.
- Build consensus from the ground up.
- Obtain agreement among participants that there is a clear need for community-wide intervention.
- Be sure participants are willing to work on mutual objectives.
- Include unrestricted funding (even small amounts) and allow the partnership to decide how to spend it.
- Require in-kind or financial contributions from each participant, so they become vested in the project.

Sustaining the Partnership

- For the first project, design a visible, clearly beneficial, low-cost intervention that may be accomplished within 12 months (e.g., community-wide practice guidelines).
- Appoint or hire a local site coordinator.
- Ask for expert assistance when needed.
- Build an evaluation plan into projects.
- Design a long-range plan with intermediate goals that provide early success.
- Gain visibility for the successful implementation of various projects.

Creating a Successful Intervention

- Be consistent with the work of other health care quality players (e.g., quality improvement organizations, state department of health, purchasing coalition, or medical society initiatives);
- Build inter-organizational links and foster group cohesiveness;
- Impose minimal, extra administrative and financial burden on participants;
- Leverage existing interventions.

Finally, the authors conclude that community partnerships will have an easier time involving the entire community and getting started in health care markets that are:

- Relatively stable; and
- Relatively consolidated, with key participants included.

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INTRODUCTION

Observers in the United States and abroad are seeing a growing interest in community-wide efforts to prevent and treat health problems. Within the United States, there is special interest in translating evidence-based medicine into quality improvement initiatives for chronic public health problems like diabetes. The market-based health insurance system in the U.S., however, presents complications because it provides many Americans with choices of competing health plans. Although competition can encourage the development of innovative benefit packages for the general population, competition can also create barriers, preventing health plans from exploring innovations in chronic care management.

The first barrier is the threat of disenrollment, or losing health plan enrollees to competitors. As much as 30 percent of a health plan's total enrollment may disenroll in a year.¹ This may be perceived as a disincentive for health plans to make investments particularly targeted at individuals with costly chronic health care needs. Such investments make the health plan more attractive to higher-cost patients (a situation known as adverse selection), and less competitive. At the same time, the success of educational and other programs may only become evident after the individual has left the health plan.

In 1997, the AHIP board of directors began to discuss ways to highlight the work of health plans in addressing the health care needs of persons with chronic conditions. There was some evidence that, compared to indemnity insurance plans and loosely structured preferred provider organizations (PPOs), the more tightly structured PPOs and health maintenance organizations (HMOs) are well positioned to improve outcomes through targeted interventions directed at both physicians and patients.² The AHIP board discussed diabetes, asthma, and cardiovascular disease. These conditions are all very common and each has a strong scientific evidence base defining effective clinical management and cost-effective treatments. The AHIP board endorsed a project focusing on diabetes as a first initiative.

People with diabetes are represented by a strong organization, the American Diabetes Association (ADA). Like AHIP, the ADA is well organized, has both advocacy and education missions, and is the predominant association in its area. At the same time,

ADA was seeking ways to provide more services to its physician members. Physicians have debated differing health plan guidelines, and in some cases, these guidelines were inconsistent with those of the ADA. When approached by AHIP, ADA saw an opportunity to be more active in the health plan arena.

In June 1998, AHIP and ADA formally established a five-year partnership, called Taking on Diabetes (TOD). Three pharmaceutical companies interested in diabetes management programs—SmithKline Beecham, Pharmacia & UpJohn, and Schering–Plough—sponsored the development of the national initiative. In subsequent years, GlaxoSmithKline (a merger of SmithKline Beecham and Glaxo Wellcome) became the exclusive supporter. It continues to fund TOD through an unrestricted educational grant.

The initial tasks of the AHIP–ADA partnership were to form an advisory group, to design an implementation plan, and to establish a website³ as a central means of communication. TOD has three components: workplace initiatives, in collaboration with the Employers Managed Healthcare Association;^{*} the best practices database; and community partnerships. The community partnerships component is the subject of this report.

The AHIP–ADA advisory group quickly hit upon the notion of fostering community-wide partnerships. It reasoned that, if all health plans in a market acted together to improve patient care, the fiscal problems caused by inadequate risk adjustment and enrollment turnover would be ameliorated. The community partnerships are attractive to each constituent group for the following reasons:

- AHIP believes this approach shows health plans they can do more for their communities through collaborative, rather than individual, efforts. The opportunity to improve diabetes care is amplified by involving all stakeholders (community organizations, physician organizations, health departments, and competing health plans).
- Health plans, especially the models that are more loosely structured than group or staff model plans, believe this partnership can be effective in changing medical practice in physicians' offices.
- ADA, which has always been active with community-based volunteer organizations for people with diabetes, sees this as a good opportunity to be more

^{*} The Employers Managed Healthcare Association is now a part of the National Business Group on Health (formerly the Washington Business Group on Health).

directly involved with primary care physicians and health plans providing diabetes care.

TOD established community partnerships in three locations: Albuquerque, New Mexico; Kansas City, Missouri; and Westchester County, New York. To support these partnerships, The Commonwealth Fund awarded AHIP a three-year grant in 2000 to place part-time, on-site coordinators at each location. In 2001, The Commonwealth Fund made additional funds available for a formative on-site program evaluation. The purpose of the evaluation was to answer these questions:

- What attributes and events resulted in competing organizations coming together?
- What is necessary to sustain these community partnerships?
- What recommendations can be made to replicate this approach for other chronic conditions and in other communities?
- To what extent do local market characteristics and structures set the direction of community partnerships and influence success?

METHODS

The evaluation used retrospective case studies,⁴ including the following multiple data sources and methods to enhance the internal validity of the research:

- Document content review of websites, press packets, meeting minutes, on-site coordinator notes, and TOD newsletters.
- Direct non-participant observation (Albuquerque and Kansas City, only). This allowed the researchers to cover events in real time and to see the organizational dynamics at those two sites.
- Structured telephone interviews with the following key informants: each on-site coordinator; the two initial project managers at AHIP and ADA; two of the current initiative managers at AHIP; each medical director at the active participating health plans; and a few other individuals. Each interview lasted from 30 to 60 minutes.
- A descriptive analysis of each site's health care market structure.

The review of the literature on group dynamics and health care partnerships generated 50 attributes thought necessary for successful establishment and sustainability of groups and community health partnerships.^{5,6} The authors grouped these attributes into eight domains: governance/accountability, nature of the problem being addressed, composition, differentiation, coordination and integration, centrality, alignment, and market structure. The semi-structured interviews covered each domain. The authors measured the strength of agreement for each attribute as reported by the participants, and paired the attributes with the community partnership outcome at each site. Appendix 1 provides a more extensive description of the methods.

FINDINGS

The primary finding is that competing health plans and local organizations can establish and sustain viable partnerships around a shared goal. This successful outcome may be reached by following different paths, starting from different origins, and operating in different environments. A nascent community partnership does not need to meet a set of hard criteria, be located in a particular type of market, or follow a particular protocol. Rather, sponsors of community partnerships must pay careful attention to principles of group dynamic theory, such as fostering a sense of belonging to the group, sharing information and plans, and aligning individual goals with group goals.

OVERVIEW OF THE PARTNERSHIP SITES

One of the questions underlying this formative evaluation is the role of local market characteristics and structures in setting community partnerships' direction and successes. Appendix 2 shows the statistics for the three sites in 2000, the year each partnership was started. The descriptions of membership characteristics and enrollment data of the communities reflect the status at the time of the evaluation study. They do not reflect changes that may have occurred since then.

Albuquerque, New Mexico, is a very consolidated market, with four HMOs ranging in size from about 9,000 members to over 181,000 members. An integrated delivery network owns the dominant HMO. No new plans have started in more than 10 years. Albuquerque has the highest HMO penetration of the three communities: 82 percent of the private market, and two-thirds (66 percent) of the total insured market.

The Kansas City, Missouri, market is the least consolidated. Although HMOs and PPOs combined have about 90 percent of the private sector market, enrollment is fragmented across 18 health plans, with no dominant player. There is a great deal of churning, and there have been several new start-ups between 1998 and 2000, as well as some dramatic departures.

The health plan market in Westchester County, part of the New York metropolitan area, has an intermediate degree of consolidation. Three-quarters of the market is divided nearly evenly across three long-established health plans, with the remainder of the market composed of 15 much smaller health plans. Despite their long-standing availability in the area, HMOs have only a 32 percent penetration of the insured market, and 40 percent of the private market.

Penetration of the Medicaid market varies from a high of half (53 percent) in Albuquerque to a low of 15 percent in Westchester. The Medicare market penetration is about one-third (30 percent) in Albuquerque, and about one-fifth in Kansas City and Westchester (22 percent and 18 percent, respectively). The HMOs in all three markets curtailed their Medicare risk enrollment and/or service areas since the middle of the 1990s, citing low reimbursement. This has implications for the community-wide delivery of diabetes interventions for Medicare and Medicaid beneficiaries. The recent exit of health plans from certain markets has shown that plans are reluctant to invest funds and time to develop long-range targeted programs if they think the state or federal reimbursement rates are unstable and will not allow them to continue to participate.

Finally, each community has a different character that affects the prevalence of diabetes and the operational logistics of interventions. Albuquerque has a low population density and is rural in nature. Over 40 percent of Albuquerque's population is uninsured or on Medicaid; of the three communities, it has the lowest income and the highest poverty rate. About 20 percent of its population is Latino and 4 percent Native American. Westchester is nearly the polar opposite. Over one-third of its adult population is college-educated and its median household income is 1.5 times that of Albuquerque. About 15 percent of its population is African American and 10 percent is Latino. Kansas City is not as rich as Westchester nor as well educated as either Albuquerque or Westchester but has a greater percentage of people with jobs and public or private health insurance. The business sector is actively engaged in monitoring and improving health care for the Kansas City area through multiple initiatives. About 20 percent of its population is African-American.

ALBUQUERQUE, NEW MEXICO

Origin

The ADA and AHIP identified Albuquerque as the first site for a community partnership. It was attractive because of its high health plan penetration, the long history of HMO activity in the city, the presence of health plans with good data collection and reporting capability, and solid long-standing professional relationships between AHIP and most of the key market players. New Mexico had only a few players (four health plans), and these players were already talking to each other. The health plans' physician networks overlapped each other to a large degree. Thus, it seemed to be a good opportunity to see if health plans and providers could be motivated to develop a common practice guideline. Finally, diabetes prevalence is very high in New Mexico. Each health plan had individually tackled diabetes for years but wanted to do more. One person interviewed for

the study said, “The timing was right. This never would have happened three or four years ago.”

In October 1999, AHIP and ADA announced Albuquerque as the pilot site. New Mexico Health Care Takes on Diabetes (NMHCTOD) became the name of the newly formed partnership and served as a catalyst to bring competing organizations together. The first meetings began in November with three of the four health plans in the locale (Cimarron, Presbyterian Health System, and Blue Cross and Blue Shield of New Mexico).

Composition

At the first meeting, the NMHCTOD staff quickly identified four collaborative projects and invited nine additional entities to participate as partners: Lovelace-CIGNA, University of New Mexico (UNM) Health Sciences Center, New Mexico Department of Health, Duran Central Pharmacy, UNM Department of Family and Community Medicine, UNM School of Pharmacy, Indian Health Service (IHS), New Mexico Primary Care Association (all qualified health centers and rural health centers), and the American Diabetes Association’s New Mexico regional office.

The New Mexico Medical Review Association (NMMRA) was an important recruit from the beginning and helped to assemble local “thought leaders” in diabetes to identify and prioritize helpful interventions. Some of NMMRA’s participation is funded by the New Mexico State Health Department. NMHCTOD meetings were held at NMMRA and participating health plan offices. One of the senior NMMRA analysts attended all NMHCTOD meetings and was careful to dovetail the diabetes activities to maximize leverage. NMMRA also supplied some logistical support, such as mailing guidelines to over 6,000 physicians. (See Interventions section.) NMMRA helped to organize meetings and worked behind the scenes with the on-site coordinator, utilizing relationships and connections throughout the state. On the flip side, the community partnership viewed NMMRA as a neutral body involved in data collection for confidential sharing of Health Plan Employer Data and Information Set (HEDIS) data.

Marian Parrot, MD, then vice president of clinical affairs at ADA, attended many formative, quarterly, and follow-up meetings and press conferences. One health plan medical director offered the opinion that the participation of the American Diabetes Association was very valuable. He said it, “signaled that, at the national level, this [effort] was important.”

The group designed a logo to develop an identity for the partnership and brand the materials. All meetings are well attended by all key players (the University of New Mexico, NMMRA, and the New Mexico Department of Health). The NMHCTOD participants viewed the IHS as a key player in addressing diabetes statewide, but the IHS has its own funding and governance and guidelines tailored to Native Americans. This has constrained IHS participation.

New Mexico's Department of Health viewed its participation, according to a statement, as fulfilling its responsibility to bring "the public health perspective in diabetes prevention and control for the state of New Mexico. This [community partnership] is a broader vision of diabetes care than the typical picture presented by the health plans. Their vision is more parochial: here are my doctors; here is my health plan; what do I need to do for my members and providers?" Through the community partnership, the local health plans and the Department of Health have created a vibrant symbiosis to improve the processes of diabetes care.

Interventions

The people interviewed said it took about six months of meetings to establish real dialogue. NMHCTOD identified four potential projects: community-wide practice guidelines, a shared set of performance standards, a community profiling mechanism, and the development and dissemination of a toolkit for professional practice. Once the group started to focus on a single product (the common practice guidelines), everyone felt more connected. By March 2000, they had determined the elements of the common guidelines, and by mid-May reached a consensus on the guidelines' elements, periodicity, and wording. In July 2000, the partners began presenting the finalized guidelines to external groups for endorsement and sign-off.

In the words of one interviewee, "What worked well was a strong and successful effort to line up every conceivable player." Ultimately, 22 organizations endorsed the guidelines, including local hospital systems, the New Mexico Medical Society, and the University of New Mexico. NMMRA and the New Mexico Department of Health worked together to issue the guidelines statewide and they were announced by the state Commissioner of Health at a press conference on November 20, 2000. The materials featured the NMHCTOD logo. Items included a pocket-sized card, posters on foot care in both English and Spanish, a large bookmark, and an 8.5-inch by 11-inch chart on heavy stock. NMMRA donated staff time to mail copies to 6,000 physicians. For further dissemination, GlaxoSmithKline also supplied copies of the materials to their local representatives who routinely visit physicians' offices.

The successful rollout of the guidelines set the stage for the other three interventions. Nine months after the start of the program, the NMHCTOD turned its attention to measuring community-wide performance on diabetes and to developing measures that could show that the community partnership had some impact on diabetes care. The NMHCTOD formed a data subcommittee and went through several iterations of measures and possible data that could be collected. The subcommittee narrowed down a wish list to aggregating the Diabetes Quality Improvement Project (DQIP)⁷ measures from the different health plans and their Medicare/Medicaid lines of business. Since the four plans comprise nearly 100 percent of the insured community, the pooled information should provide a good surrogate for a community-wide measure.

The four plans decided to try to submit their proprietary DQIP data to the NMMRA, which would then pool the data and develop a separate report for each health plan showing how it compared to the aggregate. NMMRA agreed to serve as the trusted independent broker to protect proprietary information, and contributed staff time for data analysis and manipulation. Despite encountering some challenges, the plans were able to combine their data and showed significant improvement in resources.

The third initiative was a diabetes toolkit to support physicians. This initiative had a clear set of goals: to be useful to practitioners; to not duplicate what they already have; to be free or low cost; and to meet actual demands made by the physicians (and not what the NMHCTOD perceived the needs of physicians to be). At the time of the interviews, the toolkit was envisioned as a series of papers addressing one topic each. Each health plan will include the quarterly insert with routine provider communication mailings. The inserts focus on the ABCs of good diabetic care and started with a description of eye exams to prevent diabetic retinopathy. Each insert will include an overall perspective on how New Mexico is doing in diabetes management; reiterate the guidelines; and indicate three or four resources available on the website or by mail. The inserts are part of ADA's nationwide outreach efforts.

The last project focused on working with NMMRA to help physicians develop diabetes registries of their patients. The original idea was to develop common content for provider profiles and create a statewide diabetes registry. Within a few months, the partnership and NMMRA realized that a centralized registry would not be practical in New Mexico due to privacy and confidentiality issues. Instead, they decided to encourage physicians to start their own practice-based registries using common software tools to facilitate practice comparisons. The NMHCTOD secured additional regional funding from GlaxoSmithKline to abstract data for populating the registries. A software tool, called

Diabetes Management System (DMS),[†] provides physicians with an instrument for continuous quality improvement and monitoring of clinic interventions, lab tests, and other activities. It helps physicians to track and plan diabetes management services, but it requires a degree of computer literacy that the NMMRA has had to help physician practices achieve.

Activities in 2002

NMHCTOD continued to expand their activities in 2002. Activities included revising the guidelines to include the recent revisions by the American Diabetes Association; continuing to work on the pilot diabetes registry at three sites; mailing the toolkit and materials; and developing and distributing inserts to the medical society newsletter addressing the ABCs (i.e., HgbA1c, blood pressure, and cholesterol) of diabetes. The group continued to meet regularly and explored opportunities for funding future activities.

Lessons Learned from Albuquerque

Clearly, Albuquerque is a success. Many people interviewed there attribute some of this success to the stability of the partnership throughout the start-up period, when the work of external facilitators was important. One medical director said, “What makes this work is the AHIP infrastructure and technical and administrative support.” For example, AHIP helped to take the content of the guidelines and make it more attractive. AHIP also facilitated the quarterly meetings and work groups, and helped the work groups do planning and goal setting. “Without AHIP, [the partnership] would not have gone on,” one participant said.

Interviewees also mentioned the importance of outside funding. One medical director said, “It is easier to agree to give the collaborative a try if it is only costing some time. It is easier to reach agreement on a purpose when the money is coming from an external source.”

When the authors asked medical directors what they gained from participation, they cited attributes consistent with forming a successful group. “All the players are sitting at the table and have developed personal professional relationships that did not previously exist,” one participant said. Furthermore, there is a belief that the NMHCTOD adds value and will continue. “We can take it wherever it needs to go,” another participant said. The

[†] The Diabetes Management System (DMS) was developed by the American Diabetes Association. Its current sixth version is distributed by Harbor Software International, available at <http://www.harborsoft.com/recognition.html>.

NMMRA is also a winner, reporting that they have incorporated their experience with NMHCTOD into their work with providers across the state.

The following suggestions summarize the lessons from the Albuquerque experiment:

- Identify unbiased facilitators and unrestricted funding to get things started;
- Get all key players at the table;
- Build consensus from the ground up;
- Leverage initiatives by designing efforts that are congruent with other health care quality players;
- Gain visibility for success.

The NMHCTOD appears to be ready to wean itself from AHIP and become self-sustaining. As the NMHCTOD moves more into direct physician interventions, NMMRA believes it might be able to take on AHIP's role of neutral facilitator. However, many health plans question if NMMRA can be unbiased, given its role as a federal quality improvement organization.

WESTCHESTER COUNTY, NEW YORK

Origin

In contrast to Albuquerque, where the AHIP–ADA partnership served as a catalyst to form the group, an area group—the New York State Health Plan Association (HPA)—already existed. Composed of 29 health plans, the HPA had a long track record of working on issues important to the industry, partly as a defensive measure against a very active and assertive state legislature. The state legislature is very interested and engaged in the New York State health insurance market, passing numerous state statutes relating to premiums, small group health insurance, and health plan financial stability.

In 1998, the medical director's group of the HPA decided it wanted to work on a clinical collaborative project where it could demonstrate meaningful improvements in health outcomes. The group identified asthma and diabetes. It developed criteria, performance measures, and objectives based on the Healthy People 2010 goals.⁸ After several meetings, the group selected diabetes because it is a condition with wide agreement on evidence-based guidelines.

The HPA staff drafted a proposal for health plans in the same geographic area to collaborate with one another and with other community organizations. HPA submitted the proposal to the New York State Health Department in the fall of 1999 and received some funding.

HPA initially contacted AHIP for materials to support the common guideline development, as well as to provide some direction. When the ADA and AHIP rolled out the TOD partnership, HPA expressed interest in signing on as a community partnership site. From AHIP's perspective, this was geographically attractive because there was already a partnership in a western state (i.e., New Mexico).

The HPA hosted a conference call with its medical directors, who felt that a statewide initiative was too ambitious. HPA initially wanted to focus on Albany, the state capital, since the health plans there had prior collaborative experience. However, those plans were already committed to other work. Subsequently, HPA selected Westchester County, just outside New York City, for the pilot intervention. It felt that New York City itself would be too ambitious, too large, and too diverse. Westchester was a good mix of urban and suburban centers, with characteristics of both upstate and downstate health plans. Moreover, Westchester has a high incidence of diabetes and many HMO enrollees.

Composition

The Westchester Diabetes Coalition is a larger group than the partnership in Albuquerque, but still effective. It also includes community physicians more directly than Albuquerque. This coalition includes, as equal partners: the HPA, health plans serving Westchester County, the New York Society of Internal Medicine, New York chapter of the Academy of Family Physicians, and the New York State Medical Society. These partners shared an interest in forming a strong group around the issue of patient care and physicians continue to attend most meetings. The coalition also includes the state Department of Health and the state's peer review organization, Independence PRO (IPRO). The Westchester County health department is very active and very enthusiastic about the coalition's objectives. The New York Academy of Pediatrics is not a member currently because the initial focus is on Type 2 (adult onset) diabetes. Also, there is no formal representation of diabetes educators, though one individual has expressed interest. In contrast to Albuquerque and Kansas City, the on-site coordinator was a staff member of the state HPA instead of an individual hired by AHIP and the local site. The HPA staffer is responsible for much of the paperwork, meeting coordination, and other administrative duties. AHIP provides some logistical support.

Interventions

The first meeting of the Westchester Diabetes Coalition was held in December 1999. To broaden the coalition, the initial group members decided to identify other community organizations and health plans outside the HPA. The coalition also decided to standardize guidelines because it was a task that the health plans could work on together and the providers would appreciate. Because IPRO had already produced its own guidelines and reminder systems before joining the coalition, HPA met with IPRO, agreed on guideline content, and incorporated IPRO's artwork into the coalition mailing to physicians.

The mailing consisted of a toolkit, which was distributed in October 2000 to 1,200 physicians in coordination with a press event. The toolkit, similar to Albuquerque's, consisted of posters, pocket cards, bookmarks, and patient-teaching materials that could be easily copied and distributed by physicians. The coalition hired a consulting firm to conduct a telephone survey of physicians who received the toolkit. They found that physicians who had specifically requested the toolkit were very satisfied with the contents. In contrast, 72 percent of physicians who had not asked for the toolkit did not remember receiving it. One-half of this group expressed interest in the information and requested that it be sent to their office managers' attention.⁹

Activities in 2002

After producing the initial toolkit, the coalition pursued several activities simultaneously. It developed and distributed a form that could be used for referral and documentation of eye exams. This form has been used in other settings to increase the frequency and improve the documentation of eye exams. It also conducted focus groups of patients, primary care physicians, and endocrinologists. The focus groups identified opportunities and challenges for the health plans. At the end of 2002, the coalition approached the state health department for support in starting patient registries with physician practices in Westchester. The state wrote this project into its proposal to the CDC and was funded through 2004. In addition, the coalition received funding to start a similar coalition of organizations in Suffolk County.

Lessons Learned from Westchester County

Westchester County illustrates the importance of thinking ahead. Unlike Albuquerque, which had to go through the process of forming a cohesive group, Westchester already had a group. Its challenge was to produce a series of achievements to maintain momentum and document the impact of the achievements.

As one medical director said, “Adopting the objectives of the coalition was not difficult.” Another medical director said that participating in the coalition caused his health plan to “put diabetes in the center of our work.” A third found the coalition to be most beneficial at the personal level. He was stimulated by the mutual professional support for a single set of guidelines, by shared learning about what works well and what doesn’t in terms of health plans’ interactions with providers, and by the camaraderie in moving toward a common goal. He is very motivated and interested in forming other coalitions and disease management programs that “get providers with overlapping health plan contracts all on the same page.”

Still another medical director appreciated the sense of common ground or “working on the same side.” The coalition was a close fit in terms of corporate culture. His nonprofit health plan sees itself as a public health provider, and the toolkit made it clear to physicians and patients that his plan is interested in improving quality.

Although the individual health plan and physician group representatives shared a common mission and believed in collaborating, they had not realized that their organizations needed to contribute staff time and money to enact the ideas and evaluate impacts. For example, not all health plans had the funds to print and distribute the toolkits and guidelines. Several people mentioned the possible benefits of having full-time, dedicated staff instead of spreading the work among various consultants and HPA employees.

The Westchester example also demonstrates the problem of pursuing a great idea, but not being able to quickly document the value of the invested time, effort, and expense. It is difficult to sustain participation at the corporate level without collecting information that demonstrates to a chief financial officer that staff investment brings a return on investment in the sense of improved health care quality or financial performance.

Finally, some nationally owned Westchester coalition health plans encountered difficulties because the guidelines adopted by the coalition were not congruent with the guidelines of the parent health care organization. This was a major stumbling block for Kansas City, too.

The following points summarize the lessons of the Westchester experiment:

- Build an evaluation plan into projects from the start;

- Physician organizations can be important partners;
- Develop a long-range plan with intermediate goals that provide early success;
- Ask for outside expert advice when needed;
- Have dedicated staff and budgets (even modest ones) to help get things done.

KANSAS CITY, MISSOURI

Origin

Kansas City followed a very different path from the other two sites. Similar to Westchester County, this was an opportune location for the community partnership. In March 1999, the AHIP had developed a partnership with the National Program for Improving Chronic Illness Care. The purpose of that partnership was to promote the Institute for Healthcare Improvement's¹⁰ Breakthrough Series (BTS) for diabetes to the TOD participating health plans. One of the health plans in Kansas City was very interested in applying the BTS to diabetes. The plan obtained funding from a local philanthropy, the Prime Health Foundation, to support the effort. AHIP agreed to serve as the coordinator under the TOD umbrella and provide additional support.

The BTS is an intervention developed to assist health plans and physicians in redesigning clinical processes to improve quality.¹¹ The BTS works through collaborations between the health plan medical director and health plan quality improvement manager on one side, and a physician practice on the other side. Each group collaboratively identifies a quality improvement objective, develops monthly tasks to achieve the objective, starts the change process, and measures results. Once the first objective is achieved, the physician practice continues on its own. The health plan then forms a relationship with a new physician practice.

Composition

The following were the formal sponsors of the Kansas City Coalition:

- The AHIP;
- The ADA;
- The Prime Health Foundation;
- Improving Chronic Illness Care, housed at the W.A. (Sandy) MacColl Institute for Healthcare Innovation at Group Health Cooperative of Puget Sound.

The BTS was the springboard for the Kansas City coalition. In effect, AHIP was recruiting health plans into two programs: the TOD initiative and the BTS. To participate in the TOD initiative, the health plan had to agree to implement the BTS. Many of the 17 health plan organizations expressed an interest in TOD and in exploring BTS, but most plans had difficulty recruiting physicians to the program. The health plans included: Family Health Partners, FirstGuard Health Plan, Health Midwest Comprehensive Care, HealthNet, Heartland Health, Kaiser Permanente, Kansas City Internal Medicine, Prime Health Medical Group, United Healthcare of the Midwest, Blue Cross and Blue Shield, Aetna-USHealthcare, CIGNA, Coventry Health Care, GEHA, Humana, One Health Plan, and Preferred Health.

The Kansas City market is very turbulent. Some of the aforementioned plans exited the market or merged with other plans during the time frame of this study. It was very difficult for health plans to commit the resources and time and to recruit enough primary care physicians to take part in the BTS, and, ultimately, only two plans participated. Intentionally (by restricting participation to health plans) or unintentionally (due to financial and time barriers required by BTS approach), the coalition turned out to be exclusive rather than inclusive.

As the BTS was gelling, the Kansas City Quality Improvement Coalition (KCQIC) was forming through the efforts of United Auto Workers/Ford Motor Corporation. This coalition contacted AHIP to discuss having TOD as a part of its effort. AHIP joined this group in May 2001. Its composition was more inclusive and more similar to the broad base of the Albuquerque and Westchester partnerships. However, at the time of this study, the KCQIC lacked the participation of endocrinologists or diabetes educators. For example, the International Diabetes Center, one of the largest ADA-accredited diabetes education associations in the area, was not a member of the KCQIC.

Interventions

The primary intervention under way at the time of the study was the BTS. Therefore, the evaluation reflects the challenges of the BTS.

In March 2000, the Kansas City Coalition on Diabetes hosted an informational meeting to recruit participants. Following the usual protocol of the BTS programs, the coalition scheduled additional two-day learning sessions for September 2000 and February 2001 with an Outcomes Congress planned for September 2001. At the initial meeting, the Institute for Healthcare Improvement presented the Chronic Care Model¹² and the BTS industrial organization technique. Several health plans were interested in the Chronic Care

Model and in applying BTS for diabetes care with physicians. These plans included Coventry Health Care, Humana, Family Health Plan, and United Healthcare. The plans contributed time and staff, recruiting physicians from their networks to attend the intensive learning sessions. Each health plan recruited one physician practice to participate in the diabetes health plan team. BTS also expected each health plan to develop its own performance targets and to identify monthly tasks. The first learning session was held July 13–14, 2000. The teams identified aims in the following categories for their first plan-do-study-act cycle:

- Physician counseling on diabetes complications (diabetic retinopathy);
- Standardizing and centralizing clinical information about diabetics in the medical record;
- Obtaining data on patients with diabetes in treatment population (two teams).

Coventry and Humana dropped out of BTS in August. By September, the TOD coalition on-site manager's reports identified four barriers to health plan participation in BTS:

- Inability to commit staff time and resources to the project;
- Difficulty recruiting practicing primary care physicians to serve as practice sites in a market dominated by network/independent practice association plans and solo/small-group practices;
- Participation in other diabetes-related projects under way in Kansas City;
- Preference for collaboration within the health plan's systems versus collaboration with other health plans on guidelines, provider reporting, etc.

In mid-September, three health plans, Family Health Partners, United Healthcare, and FirstGuard, officially signed a memorandum of understanding with TOD. The coalition's on-site manager worked closely with the health plans through phone calls and personal meetings to encourage commitment to the BTS intervention. Aetna officially joined and recruited a physician team in late September. At the end of October, United Healthcare and Family Health Partners had yet to recruit a practice site. Family Health Partners was the only team to submit the BTS-required monthly report to the coalition's coordinator. In November, FirstGuard and Family Health Partners dropped out of the BTS, both citing staff turnover. United Healthcare recruited a physician practice site, but the physicians found it difficult to devote the time demanded by BTS. They dropped out

in early January and United Healthcare identified a new practice site. Aetna recruited a practice site and became an active participant in the BTS.

At this time, the coalition started a midcourse correction. The on-site coordinator explored the possibility of collaborating on guideline development with the KCQIC sponsored by United Auto Workers/Ford, citing the success with TOD in Albuquerque and Westchester County. She also discussed whether TOD had any interest in facilitating adoption of whichever guidelines would be developed.

In February 2001, the seven members that had started with the BTS attended a presentation from AHIP on the success of other communities in developing common guidelines. Aetna, Blue Cross and Blue Shield, Coventry, FirstGuard, Humana, Preferred Health Professionals, and United Healthcare attended and reviewed materials from the Colorado Clinical Guidelines Collaborative, the guidelines and materials from Westchester and Albuquerque TOD, and an independent initiative in Michigan.

In May, AHIP joined the KCQIC, which included a focused effort on diabetes. This strategic alliance helped to expand the work of the coalition. The coalition also held an outcomes congress, where all the participants shared their results.

Lessons Learned from Kansas City

The experience in Kansas City demonstrates the importance of carefully matching the intervention with the market characteristics and priorities of the health plans. Kansas City is a turbulent market. New plans are starting up; other plans are merging together; still others are leaving. Some of the attendees at the first meeting, such as Kaiser Foundation Health Plan, left Kansas City before the TOD program got off the ground. In this business climate, the plans face the challenges of ensuring their financial stability and market competitiveness. These are challenges that may result in a hesitancy to explore unproven collaborative strategies. Also, during 2001 there was staff turnover within the health plans and among the physician team partners. This prevented internal continuity and disrupted the intervention, which intrinsically demands sustained effort.

Ideally, the community-wide intervention should complement existing plan-specific initiatives, especially if the health plan is part of a national or regional chain. Several of the Kansas City health plans already had diabetes interventions under way. Corporate headquarters directed these interventions and the local plans had little or no latitude or resources to make modifications.

The BTS has been successful at implementing rapid change and improvements in the process of diabetes care. These features initially attracted one health plan medical director. Not only was he interested in the chronic disease model, but he was excited by the prospect of creating interventions that would allow group practices to have quick success and engage providers. He also hoped it would get the group practices to think more about quality of care and quality improvement.

In retrospect, it was unrealistic to expect a small or solo practice to shut down for training sessions (a total of six days), implement the intervention, collect data, and write reports for the BTS program. As another medical director stated, “The best thing to do is to offer things to [physicians] that are *immediately* beneficial to their daily practice. For example, a database to track and recall diabetes patients so [the physicians] could monitor who needed an eye exam or a foot exam.”

Despite the problems Kansas City had creating and sustaining the coalition through the BTS, there was interest among some health plans in trying a new approach to improving diabetes care and to leveraging the employer coalitions already in existence. As one medical director said, “I think, from the coalition standpoint, we need to teach doctors that they are partners in care as opposed to the old model where they were the sole providers of care.”

Another medical director said three positive things came out of the Kansas City coalition: a greater awareness of existing diabetes resources (e.g., the ADA website) that health plans could tap into at a nominal cost; a better understanding on the part of health plans about the complex nature of medical practices and their time constraints; and learning that quick response activities like the BTS do work, but require flexibility on the part of the health plans to modify as needed.

Medical directors said the BTS intervention had trouble getting the project partners engaged and maintaining that engagement after the excitement of the initial meeting and was burdened by compliance with the monthly measuring and reporting, which was difficult due to staffing issues. They said the process could be improved by organizing the year from start to finish to include more structure.

Despite some of the disappointments with the BTS as an intervention, there were some positive outcomes. The International Diabetes Center became better known to the participating health plans, and the health plans started to refer patients to the center. The health plans gained a better understanding of the rigor and logic of quality improvement

methodologies. The BTS changed the mindset of the physicians who did participate, resulting in the physicians taking ownership of the responsibility for quality improvements. The participating health plans established relationships that had not existed before.

To summarize the lessons of the Kansas City experience:

- Match the intervention to the market;
- Design an initial intervention that fosters group cohesiveness;
- Try to gain leverage from existing interventions to minimize incremental administrative and financial burdens;
- Market instability requires a rethinking of direction and potential linkage to a stable community base.

ROLES OF ADA AND AHIP

The partnership of the two national associations (AHIP and ADA) was a key factor in moving forward each community partnership. In fact, it is possible that none of the partnerships would have made the progress they did without outside assistance. AHIP and the ADA were extremely flexible, adapting to different roles at each site. AHIP provided modest yet important funding. As a neutral outsider, AHIP helped the participants bridge different organizational cultures. AHIP provided technical assistance, particularly on strategic planning, logistical support for wide dissemination of materials produced, and ideas for supplemental funding. AHIP is well suited to this role, since it is able to draw upon its knowledge of initiatives across the country. AHIP also serves as a pollinator, carrying ideas and strategies developed at one site to the two other sites. This is second nature to national trade and professional organizations, but these are new activities for the medical directors attending their site's meetings. The partnerships turned to ADA for guidance on clinical matters relating to diabetes, particularly the development and updating of evidence-based guidelines.

At the site visits to Albuquerque and Westchester, it was apparent that AHIP staff members are skilled facilitators of both governance and operations in the partnerships. Several interviewees underscored this observation, with one pointing out that AHIP and ADA “got the health plans to set goals and time frames through mutual agreement, without coercion.” In other words, it was easier for the competing health plans to check their proprietary hats at the door and think about what would be best for their communities with a neutral party as the facilitator. AHIP was instrumental in keeping the Westchester coalition together after it completed the guidelines.

Table 1 shows how the AHIP-ADA partnership adapted its role to the specific requirements of each site.

Table 1. Selected Features of the Three Sites

	Albuquerque, N.M.	Westchester County, N.Y.	Kansas City, Mo.
Group origin	TOD formed it	Already formed	Weakly formed
Role of AHIP-ADA	Catalyst; initial leadership	Recruited as outside expert, particularly to sustain	Recruited as matchmaker; later navigated midcourse correction
Initial project	Common guidelines	Common guidelines	BTS for <i>selected</i> doctors
Financing (staff and in-kind contributions)	Combination of state, PRO, TOD.	N.Y. State HMO Association; some state; TOD	Local foundation funding; TOD support of BTS

Notes: BTS, Breakthrough Series; TOD, Taking on Diabetes.

ORGANIZATIONAL CHARACTERISTICS OF EACH PARTNERSHIP

The literature review of community partnerships and health care alliances revealed little statistical association between market structure and the presence of these activities.^{13,14,15,16} The authors concur with other researchers that human factors play a crucial role.^{8,9,17,18,19}

Table 2 shows the simple mean score at each site for the organizational domain, as described by key participants at each site. Each TOD community partnership site presents a different configuration of need, composition, alignment, governance/accountability, coordination, and market structure. Yet, each site was able to establish a partnership, supporting the proposition that there are many different combinations of factors that can result in a successful start-up.

Table 2. Attribute Strength and Partnership Outcome, as Scored by Participants

<i>Causes to Establish Partnership</i>	<i>Governance/Accountability</i>	<i>Need</i>	<i>Composition</i>	<i>Coordination and Integration</i>	<i>Impact Measures</i>	<i>Alignment</i>	<i>Market Characteristics</i>	<i>Successful Partnership</i>
Albuquerque	0.90	0.95	0.83	1.00	N/A	0.92	0.60	1.0
Kansas City	1.00	0.76	0.73	0.95	N/A	0.26	0.42	0.66
Westchester	1.00	1.00	0.76	0.95	Not app.	0.68	0.68	1.0

<i>Causes to Sustain Partnership</i>	<i>Governance/Accountability</i>	<i>Need</i>	<i>Composition</i>	<i>Coordination and Integration</i>	<i>Impact Measures</i>	<i>Alignment</i>	<i>Market Characteristics</i>	<i>Successful Partnership</i>
Albuquerque	0.81	0.90	0.68	0.70	0.83	0.92	0.61	1.0
Kansas City	0.76	0.58	0.52	0.57	0.41	0.26	0.41	0.17
Westchester	0.71	1.00	0.67	0.71	0.85	0.68	0.60	1.0

Notes: 0, no relationship; 1, complete relationship.

Unfortunately, the study’s limited sample size prevented the authors from investigating which specific attributes or combination of attributes within each domain are necessary or sufficient to establish and sustain effective partnerships. Appendix 2 presents the mean attribute strength as measured by the participants interviewed at each site.

Despite the small sample size, the authors tentatively concluded that market structure plays a more important role in the success of the intervention, not in whether a community health partnership is successfully established. For example, most health plans in Kansas City were not ready to take on the BTS. Yet, the community partnerships in both Albuquerque and Westchester subsequently considered the BTS as their next intervention. Community partnerships can be established in churning markets, but they are much more difficult to sustain.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

This study suggests several key features that will facilitate the likelihood of competing health plans agreeing to work together on chronic care management programs.

Features associated with successful *establishment* of a community partnership are:

- Unbiased facilitators and unrestricted funding;
- An active coordinator;
- A contribution by each participant (in kind or financial) to become vested in the project;
- A strong local champion to ensure the feeling that the project was invented locally;
- Consensus built from the ground up;
- Agreement that there is a clear need for community-wide intervention;
- Willingness by participants to work on mutual objective;
- Relatively stable health care market;
- All key participants comprise small core group.

To successfully *sustain* a community partnership:

- Accomplish a visible, clearly beneficial, low-cost intervention (e.g., community-wide practice guidelines) within 12 months;
- Retain a local site coordinator dedicated to the partnership;
- Ask for expert outside assistance when needed;
- Build an evaluation plan into projects;
- Develop a long-range plan with intermediate goals that provide early success;
- Gain visibility of success.

To create a successful *intervention*:

- Leverage initiatives by designing efforts that are congruent with other health care quality players (e.g., PRO, state department of health, purchasing coalition, or medical society);
- Select an intervention that will build inter-organizational links and foster group cohesiveness;
- Try to gain leverage from existing interventions to minimize incremental administrative and financial burdens.

The authors also note that the initial intervention need not show a direct link to quality improvement, even if quality improvement is the primary mission of the partnerships. It may be more important to work on a widely recognized need, such as developing a community-wide guideline. The initial intervention should be nonthreatening and achievable in a short time period. The primary benefit it is to give the group a tangible product and allow the building of personal relationships across competitive lines. After an initial, group-coalescing intervention, the partners may be ready to tackle more ambitious projects with direct links to quality improvement.

APPENDIX 1. METHODS

The authors used readily available, existing data sources to identify local market characteristics and structure. The eight primary sources were: the *AHIP/Dorland Directory of Health Plans*²⁰ (specific plan information); Area Resource File²¹ (physician supply data); U.S. Census Bureau²² (demographic and business data); InterStudy Publications²³ (managed care statistics); IHS HealthGroup²⁴ (health care market information); Kaiser Family Foundation State Health Facts Online²⁵ (statewide statistics and facts); American Health Line²⁶ (specific state legislation); and CDC Diabetes²⁷ Web pages.

INSTRUMENTATION

Development of the partnership criteria. The authors' review of business and health care literature led them to identify 50 attributes associated with the presence of successful community groups and partnerships.^{8,18-23} They grouped these attributes into seven domains based on the typology suggested by Mitchell and Shortell.⁵ They subdivided these attributes into those that are hypothesized to be present for "establishment" and those that are hypothesized to be present for "sustainability," allowing some attributes to be present at both stages. They developed semi-structured, open format interview questions based on these seven domains. Table A-1 shows the seven domains plus an additional domain regarding market structure, based on information gathered from other sources; the 50 specific attributes with definitions; and the underlying hypotheses stating the significance of each attribute for establishment and sustainability of each partnership.

Table A-1. Attributes, Scoring Values, and Hypotheses

Domains and Attributes of Partnerships	Number of Values	Fuzzy Set Scoring Scale			Hypothesis
		0.0 (Fully Out)	0.5 (Neither Out Nor In)	1.0 (Fully In)	
Domain I. Index of Governance/Accountability					
a. Impetus to Form Partnership	7	None	Weak	Strong	Need strong reason to establish partnership
b. Impetus to Maintain the Partnership	7	None	Weak	Strong	Need strong reason to maintain partnership
c. Involvement of AHIP					
1. Initial	7	Not present	Weak	Strong presence	Since involves health plans, need AHIP at start
2. Continuous	7	Not present	Weak	Always present	Since involves health plans, need AHIP at every meeting
d. Involvement of ADA					
1. Initial	7	Not present	Weak	Strong presence	Since it is diabetes, need ADA to establish
2. Continuous	7	Not present	Present 1/2 the time	Always present	Since it is diabetes, need ADA to maintain
e. Financial Accountability	7	Not present	Ad hoc tracking of expenses	Complete financial statements	Need to “mind the store”
f. Contributions by Partners	7	No public	Small percentage	More than 25%	Need financial buy-in of public sector and private funds for public-private sector partnership
g. Continuous Funding Available	7	Not present	Hinted at	Assured	Need assurance that partnership is a “going concern”
h. Funding for Subprojects	7	Never	Sometimes	Always	Partnership needs to have the financial resources to continue operationalizing interventions
i. Meeting Coordinator	7	Not present	Present 1/2 the time	Always	Need coordinator to make the meetings happen and do follow-up
j. Clear Decision-making Strategy	7	None	Unclear	Very clear	Need to have a clear decision-making process so things are done
k. Tracking Progress Toward Objectives					
1. Developed	7	No system	Informal system	Comprehensive	Need process to show something is being accomplished
2. Conducted	7	No	Incomplete	Complete	Need to monitor progress to measure success and/or take corrective actions

Domains and Attributes of Partnerships	Number of Values	Fuzzy Set Scoring Scale			Hypothesis
		0.0 (Fully Out)	0.5 (Neither Out Nor In)	1.0 (Fully In)	
l. Outcome-oriented Evaluation Tools	7	None	Under discussion	Established	Need to show that partnership has a reason to exist Only professionals can do an evaluation
m. Professionals Used for Evaluation	7	No		Yes	
Domain II. Nature of the Problem Being Addressed					
a. Common Mission or Vision Established	5	No	Vague	Clear	Need to have a common, shared mission
b. High Motivation for Competing Organizations to:					
1. Join Partnership	5	No	Maybe	Yes	Need to have strong motivation to join
2. Participate in Partnership	5	No	Maybe	Yes	Need to have strong motivation to stay
c. Agreement on Problem Definition	5	No agreement	Some agreement	Strong agreement	Need strong agreement on the problem
d. Development of Clear Goal-Setting Strategies	5	None	Vague	Clear	Need clear strategy to set long-term and interim goals
Domain III. Partnership Composition					
a. Participation of Key Players	5	Many missing	A few missing	None missing	All key players need to be involved
b. Membership Composition Involves Active Public Sector Participation	5	No	Minimal public	Strong public	Need to have public sector involved
c. A Local Champion or Impetus Occurred	5	No		Yes	Need at least one local champion
d. Collaborative Environment Present at Start-up	5	No	Weak	Strong	Need a collaborative environment
e. PRO is Essential Player (Role of PRO)	5	No	Weak	Strong	PRO must have a strong role
f. Core Group Present	7	Absent	Fluctuates	Always present	A core group is always present
Domain IV. Index of Differentiation					
a. Homogeneous Group at Start-up	5	Mix	Mostly one type	All one type	Homogeneous groups are more likely to have successful start-up
b. Homogenous Group Ongoing	5	Mix	Mostly one type	All one type	Homogeneous groups are more likely to have successful continuation
e. Only Selected Players Involved	2 (crisp)	Yes		No	Everyone should be involved, not just selected players
f. Key Player NOT Involved	2 (crisp)	Yes		No	Every key player should be involved

Domains and Attributes of Partnerships	Number of Values	Fuzzy Set Scoring Scale			Hypothesis
		0.0 (Fully Out)	0.5 (Neither Out Nor In)	1.0 (Fully In)	
Domain V. Coordination and Integration					
a. Active Meeting Coordinator Present	3	Never	Sometimes	Always	Need active meeting coordinator
b. Local Site Coordinator Present	3	Never	Sometimes	Always	Need local site coordinator
c. Equal Involvement of All Participating Members	7	Not equal	Some more equal than others	All equal	Need equal involvement
d. Copes with Difficulties/ Unsuccessful Initiatives	3	Unable to cope	Partially copes	Copes completely	Need to be able to cope
e. Mutual Sense of Ownership or Buy-in	7	Not mutual	Some mutuality	Complete mutuality	Need mutual sense of ownership or buy-in
f. Partnership Relies on Formal Contracts Established	3	Completely informal (e.g., consensus)	Both formal and informal	Completely formal	Need formal contract
Domain VI. Index of Centrality (Importance)					
a. Internally There Is a Sense of Accomplishment and Contribution	3	No sense	Weak sense	Strong sense	Need strong sense of accomplishment
b. Work of Organization Affected	3	Not at all	Minor way	Major way	If important, home organization has been impacted
c. Media/News Coverage Has Occurred	3	None at all	Occasional article in local press or trade	Coverage in major newspapers and trade	Need media coverage to be important
d. Backing of the Partnership from Elected Officials	3	None at all	One statement	Recurring statements	Need support from local/state government to succeed
Domain VII. Index of Alignment					
a. Match between Problems Addressed and Partnership Composition	7	No match	Weak match	Strong match	Need strong match
b. Match between Partnership Composition and Community Need/Priorities	7	No match	Weak match	Strong match	Need strong match
c. Match between Partnership Coordination of Task/Activities and Structure of the Partnership	7	No match	Weak match	Strong match	Need strong match

Domains and Attributes of Partnerships	Number of Values	Fuzzy Set Scoring Scale			Hypothesis
		0.0 (Fully Out)	0.5 (Neither Out Nor In)	1.0 (Fully In)	
Domain VIII. Index of Market Structure					
a. HMO/PPO Penetration of Commercial Market	Continuous	(Actual value)			Need high HMO/PPO penetration
b. Number of HMOs in Core	3	15+	7–14	<7	Need a few, large players
c. PCPs Contracting with HMOs/PPOs (%)	Continuous	(Actual value)			Higher percentage means managed care organizations (MCOs) can have a bigger impact in the community when make an intervention
d. Legislative and Regulatory Environment	5	None	1–3 small bills relating to HMOs annually	4+ small bills or 1 huge bill relating to HMOs	More-active legislature can force MCOs to band together as a defensive measure
e. Presence and Activity of Purchaser Coalitions	5	None or only a few employers involved	Some employers involved	Most employers involved	Need employer coalition with clout that puts a premium on quality
f. Collaborative Environment Present at Start-up (from above)	5	No	Weak	Strong	Need a collaborative environment
g. Plans with AHIP Membership (%)	Continuous	(Actual value)			AHIP can bring plans to the table
h. Stability of HMO/PPO Market	5	Immature	Consolidating, with a few large plans and many small ones	Mature	Plans in a mature market can divert resources to quality
i. Physician Integration	3	All solo	Some groups	All groups	Easier to make changes with a few large group practices

Development of the interview guide. The authors developed the interview guide based on the literature review of organizational research with particular emphasis on health-focused partnerships. They developed two versions of the interview, one for local site coordinators with 10 questions, and one for the AHIP on-site community partnership coordinators. Both versions had the same core component and captured the same domains focusing on the history, organizational developments, and successful or unsuccessful project initiatives of each partnership. The authors pilot-tested the interview guide with AHIP and ADA staff who provided feedback with regard to scope, depth, and comprehension of the questions.

Sample and data. The authors interviewed key informants for their assessment of how well each attribute applied to their particular community partnership. The study's authors conducted 23 interviews with health plan medical directors, local site coordinators and partnership coordinators across the three market sites. After orientation and training, two researchers conducted four, seven, five, and seven interviews at Washington, D.C. (at AHIP), Albuquerque, Kansas City, and Westchester, respectively. With the permission of the interviewee, the interviews were audio-taped.

Some interview participants were selected for their involvement in the community partnership (e.g., acted as on-site coordinator). Others were recruited by the on-site coordinators because they are the medical directors of participating plans. Each interview lasted from 30 to 60 minutes; 22 interviews were audio-recorded and one was received via a written response.

ANALYSIS

Scoring criteria. In scoring the interviews, the authors used the causal analysis approach developed by Ragin²⁸ in the field of political science. They considered each of the 50 attributes to be a mathematical set and then scored the degree of set membership. The authors made a distinction between “fuzzy” and “crisp” membership sets. For example, using a five-value fuzzy set (1, fully in category; 0.75, more in than out; 0.50, crossover, neither in nor out; 0.25, more out than in; 0, fully out) to score attributes that were not dichotomous or “crisp” (see columns 3 to 5 of Table A-1). Before coding the responses, the relevant domain of each attribute (the first column of Table A-1) and the empirical evidence for indexing the scores (either market information or the interviews) were determined. Although all scores ranged from 0 to 1, the authors used different numbers of values for attributes, shown in the second column of Table A-1. They did this because some attributes lent themselves to more nuanced interpretations of set membership than others. For example, the values for a seven-value attribute are: 1.00, full membership in

the set; 0.83, mostly but not fully in; 0.66, somewhat in; 0.50, crossover (neither in nor out); 0.33, somewhat out; 0.17, mostly out; 0.00, excluded from membership in the set. Three attributes were not suitable for continuous scoring, such as “at least one local champion.” For these attributes, a binary scoring system was used.

By defining anchor points, the authors placed boundaries around relevant and irrelevant variation in responses to the open-ended questions during the structured interviews. They show anchor points for the 0, 0.5, and 1.0 values in columns 3 to 5 of Table A-1. For example, the scoring of MCO penetration is: penetration < 20 percent (“fully out”; membership score = 0.0); penetration 20 percent to 59 percent (“neither out nor in”; membership score = 0.5); penetration 60 percent+ (“fully in”; membership score = 1.0).

Scoring methodology. Two analysts listened to the audio-taped interviews and independently scored them for the interviewee’s assessment of strength of association for each of the 50 predetermined attributes. Interviews were scored using a tally sheet to rate strength of set membership for each interview. In order to obtain inter-rater agreement, they compared scores, discussed differences, and reached agreement on a final score, which entered the analysis. If a respondent did not address a particular attribute, it was scored as “missing.”

After obtaining an agreed upon composite score for each domain, the authors computed a mean composite score across all respondents per each individual site. They further aggregated scores for each domain, enabling the comparison of sites by accomplishments in each domain. For example, they interviewed seven people in Albuquerque and asked each person to identify a challenge faced by the partnership and to describe how the partnership addressed that challenge. The attribute scored was “The partnership copes successfully with difficulties/unsuccessful initiatives.” The two analysts agreed that four interviewees said the partnership was successful in addressing the challenge (score = 1), while three interviewees said the partnership was somewhat successful (score = 0.5). The composite score is 0.79. This method allowed the authors to quantify the strength of the attribute at each site as perceived by the participants over the life of the community partnership.

The final step in the analysis was to group the 50 organizational and market structure attributes into eight causal variables: governance/accountability, nature of the problem being addressed, composition, differentiation, coordination and integration, centrality, alignment, and market structure. By looking at different combinations of these

variables, the authors started to specify combinations of people and market attributes that are necessary to successfully establish and sustain a community health partnership, even though they had only three case studies.²⁹ Table A-2 lists the primary attributes needed to establish and sustain a partnership and the valid mean score for each site as reported by the interviewees at that site.

Table A-2. Attributes and Composite Degree of Membership to Establish and Sustain Community Partnerships (mean scores by participants)

Domain and Attribute	Albuquerque, N.M.	Kansas City, Mo.	Westchester County, N.Y.
Governance/Accountability (Establish)			
Contributions by Partners	0.80	1.00	1.00
Meeting Coordinator	1.00	1.00	1.00
Governance/Accountability (Sustain)			
Financial Accountability	0.80	1.00	1.00
Contributions by Partners	0.86	0.00	1.00
Continuous Funding Available	0.17	0.00	0.11
Funding for Subprojects	1.00	1.00	0.63
Meeting Coordinator	1.00	1.00	1.00
Clear Decision-making Strategy	0.79	0.83	0.64
Outcome-oriented Evaluation Tools	0.93	1.00	0.67
Developed Tracking Progress Toward Objectives	0.86	1.00	0.72
Executed the Tracking	0.86	1.00	0.60
Need (Establish)			
Common Mission or Vision Established	1.00	1.00	1.00
Motivation to Join Partnership	1.00	0.90	1.00
Motivation to Participate in Partnership	0.79	0.25	1.00
Agreement on Problem Definition	1.00	0.90	1.00
Need (Sustain)			
Motivation to Participate in Partnership	0.79	0.25	1.00
Agreement on Problem Definition	1.00	0.90	1.00
Composition (Establish)			
AHIP Involvement	1.00	1.00	0.92
ADA Involvement	0.86	0.70	0.71
Participation of Invited Key Players	0.82	0.20	0.64
Every Key Player Was Invited	0.39	1.00	0.86
A Local Champion or Impetus Occurred	1.00	0.58	1.00
Core Group Present	0.97	0.78	0.92
Impetus to Form Partnership	1.00	1.00	1.00
Homogeneous Group at Start-up	0.57	0.60	0.00

Domain and Attribute	Albuquerque, N.M.	Kansas City, Mo.	Westchester County, N.Y.
Composition (Sustain)			
AHIP Continuously Involved	0.86	0.85	0.75
ADA Continuously Involved	0.24	0.30	0.14
Participation of Invited Key Players	0.82	0.20	0.64
Every Key Player Was Invited	0.39	1.00	0.86
Involves Active Public Sector Participation	1.00	0.50	1.00
External, Aligned Body Is Essential Player	0.99	0.00	0.67
A Local Champion or Impetus	1.00	0.58	1.00
Core Group Present	0.97	0.78	0.92
Strong Impetus to Maintain the Partnership	0.86	0.65	1.00
Ongoing Homogenous Group	0.00	0.00	0.00
Only Selected Players Involved	0.38	1.00	0.42
Coordination and Integration (Establish)			
Active Meeting Coordinator Present	1.00	0.90	1.00
Local Site Coordinator Present	1.00	1.00	1.00
Partnership Relies on Formal Contracts Established	0.00	0.00	0.00
Coordination and Integration (Sustain)			
Active Meeting Coordinator Present	1.00	0.90	1.00
Local Site Coordinator Present	1.00	1.00	1.00
Equal Involvement of All Participating Members	0.21	0.25	0.40
Copes with Difficulties/ Unsuccessful Initiatives	0.79	0.60	0.60
Mutual Sense of Ownership or Buy-in	0.88	0.23	0.97
Partnership Relies on Formal Contracts Established	0.00	0.00	0.00
Partnership Relies on Informal Agreements	1.00	1.00	1.00
Impact Measures (Establish)			
	N/A	N/A	N/A
Impact Measures (Sustain)			
Internally There Is a Sense of Accomplishment and Contribution	1.00	0.88	1.00
Work of Organization Affected	1.00	1.00	0.70
Media/News Coverage Has Occurred	1.00	0.00	1.00
Backing of the Partnership from Elected Officials	1.00	0.00	1.00
Members Have Request for Participation in at Least One Other Partnership	0.00	0.56	0.42
Presence of Dual Agency Representation	1.00	0.00	1.00
Alignment (Establish)			
Match between Problems Addressed and Partnership Composition	0.93	0.23	0.73
Match between Partnership Composition and Community Need/Priorities	0.93	0.23	0.64
Match between Partnership Coordination of Task/Activities and Structure of the Partnership	0.90	0.33	0.68

Domain and Attribute	Albuquerque, N.M.	Kansas City, Mo.	Westchester County, N.Y.
Alignment (Sustain)			
Match between Problems Addressed and Partnership Composition	0.93	0.23	0.73
Match between Partnership Composition and Community Need/Priorities	0.93	0.23	0.64
Match between Partnership Coordination of Task/Activities and Structure of the Partnership	0.90	0.33	0.68
Market Structure (Establish)			
HMO/PPO Penetration of Commercial Market	0.82	0.55	0.40
Number of HMOs in Core	1.00	0.0	0.50
PCPs Contracting with HMOs/PPOs (%)	0.58	0.52	0.84
Legislative and Regulatory Environment	0.25	0.50	0.75
Presence and Activity of Purchaser Coalitions	0.00	0.50	0.50
Collaborative Environment Present at Start-up Plans with AHIP Membership (%)	0.83	0.40	0.96
	0.75	0.50	0.80
Market Structure (Sustain)			
HMO/PPO Penetration of Commercial Market	0.82	0.55	0.40
Number of HMOs in Core	1.00	0.00	0.50
PCPs Contracting with HMOs/PPOs (%)	0.58	0.52	0.84
Legislative and Regulatory Environment	0.25	0.50	0.75
Presence and Activity of Purchaser Coalitions	0.00	0.50	0.50
Plans with AHIP Membership (%)	0.75	0.50	0.80
Stability of HMO/PPO Market	1.00	0.50	0.50
Physician Integration	0.50	0.20	0.50

APPENDIX 2. COMMUNITY STATISTICS

	Albuquerque, N.M.*	Kansas City, Mo.†	Westchester Co., N.Y.‡
1. Demographics (2000)			
a. Total Population	713,000	838,886	923,000
White	70.8%	76.7%	71.3%
Latino**	20.3%	2.7%	9.7%
African American	2.8%	18.8%	14.2%
Asian/Pacific Islander	1.9%	1.3%	4.5%
Native American	4.2%	0.5%	0.3%
b. Insurance Composition			
Uninsured	26%	9%	16%
Medicaid	17%	13%	14%
Medicare	13%	13%	13%
Private	44%	65%	56%
c. HMO Penetration Rates			
Private	82%	55%	40%
Medicaid	53%	43%	16%
Medicare	29%	22%	18%
Total Market	49%	45%	27%
d. Socioeconomic Status			
High School Graduates, Age 25+, 1990	82.1%	80.5%	81.0%
Bachelor's Degree or Higher, 1990	26.7%	20.0%	35.3%
Homeownership Rate, 2000	63.7%	64.6%	60.1%
Median Household Income, 1997	\$36,853	\$42,167§	\$55,040
Persons Below Poverty, 1997	14.6%	10.7%	9.3%
Children Below Poverty, 1997	21.5%	16.2%	15.2%
Foreign Born Population, 1990	5.3%	2.2%	18.1%
Age 5+ Who Do Not Speak English "Very Well," 1990	8.3%	2.0%	9.6%
Persons Age 65 and Over, 2000	11.5%	12.1%	14.0%
Population 16+ Not in Labor Force, 1990	32.3%	31.3%	33.6%
Persons per Square Mile, 2000	477	838	2,133
2. Plan Characteristics (Metropolitan Statistical Area)			
a. Number of HMOs	4	18	14
b. Average Plan Age (Years)	16	11	16
c. Number Based on Group Practice Model	1	6	1
3. HMO Network Reimbursement (Metropolitan Statistical Area)			
a. Fee for Service			
PCP	58%	52%	84%
Specialty	50%	80%	84%
b. Capitation			
PCP	9%	45%	10%
Specialty	5%	14%	10%

	Albuquerque, N.M.*	Kansas City, Mo.†	Westchester Co., N.Y.‡
4. Physician Characteristics			
a. Physicians/100,000§§	311	251	668
b. Total Active MDs, Federal and non-Federal, 1998	2,216	2,108	6,165
c. Total Active non-Federal MDs, 1998	2,096	2,074	6,068
d. Total Office-based MDs, non-Federal, 1998	1,320	1,445	3,737
e. Total Hospital-based MDs, non-Federal, 1998	482	404	1,427
f. Optometrists, 1990	68	95	114
g. Podiatrists, 1990	7	15	140
5. Purchasers			
a. Private Nonfarm Establishments with Paid Employees, 1998	15,585	22,581	30,096
b. Class of Worker			
Private Wage and Salary	72.6%	80.8%	78.2%
Government (State, Local, Federal)	19.8%	13.4%	14.5%
Self-employed	7.2%	5.4%	7.0%
Unpaid Family	0.4%	0.3%	0.3%
c. Presence and Activity of Purchaser Coalitions	None	None	Some
6. Integration of Delivery Systems	High	Low	Somewhat high
7. Legislative and Regulatory Environment	Moderate	Active	Very active
State Laws Require Insurers to Provide Coverage for Diabetic Supplies, Equipment, and/or Outpatient Management Training	Yes	All policies and plans must offer	Yes
8. Significant Health Organizations/Opinion Leaders			
a. Number of Integrated Delivery Systems	4 (+1 military)	7 (+1 military)	4 (+1 military)
b. Number of Hospitals	19	48	103
c. Number of Medical Schools	1	1	
d. Hospital Beds (in Thousands)	2.7	4.4	4.4
e. HMO Inpatient Days (Private, in Thousands)	211.4	180.4	252.7
f. HMO Inpatient Days (Medicare, in Thousands)	1,228.4	1,135.7	1,945.9
g. CDC Diabetes Control Programs, 2000	Core	Core	Comprehensive

* Bernalillo County.

† Clay and Jackson Counties. Total population for the metropolitan statistical area is 1,776,000.

‡ Westchester County.

** Derived figure, by summing other racial categories and subtracting from 100 percent.

§ Averaged median for Clay and Jackson Counties.

§§ Computed by dividing 1998 total practicing federal and non-federal MDs by 2000 census.

APPENDIX 3. SUMMARY OF HEDIS MEASURES FOR TAKING ON DIABETES COMMUNITY PARTNERSHIPS

The tables that follow contain Health Plan Employer Data and Information Set (HEDIS) data for the TOD community partnerships in the Kansas City metropolitan area; Albuquerque, N.M.; and Westchester County, N.Y. National averages for all corresponding HEDIS measures are included.

NOTES ON THE DATA PRESENTED

Kansas City, Mo., and Kansas City, Kan.

- In Kansas City, the participants in the Institute for Healthcare Improvement's Breakthrough Series were Aetna and United Healthcare.
- The HEDIS rates for the individual plans, and other averages, are taken from NCQA's Quality Compass 2001–2003 databases for the commercial population.
- The HEDIS average presented is for the Kansas City metropolitan area as calculated in Quality Compass.
- There are limitations to the HEDIS rates for Kansas City. The individual health plan rates are reported for a larger geographic area than the location of the diabetes collaborative (e.g., the Kansas City metropolitan area). The Kansas City metropolitan area average also includes more than the two health plans involved in the IHI Breakthrough Series.

New Mexico

- In New Mexico, the current participants in NMHCTOD include: Blue Cross and Blue Shield of New Mexico/HMO New Mexico, Cimarron Health Plan, Lovelace Health Systems, Presbyterian Health Plan, and St. Joseph's.
- The HEDIS rates calculated for the New Mexico Health Care TOD coalition were completed by the NMMRA. All health plans in the state participated in the coalition and complete statewide data for all populations (e.g., commercial, Medicaid, and Medicare) is reported.
- The New Mexico rates are presented in a separate table for each HEDIS measure, indicating that they are not based on the Quality Compass data.

Westchester County, N.Y.

- The current participants in the Westchester County New York Diabetes Coalition are Aetna, Affinity Health Plan, Health Net of New York, HIP Health Plan of New York, HealthSource/Hudson Health Plan, Oxford Health Plans, and United Healthcare of New York.
- The HEDIS rates for the individual plans and other averages are taken from NCQA’s Quality Compass 2001–2003 databases for the commercial population. Rates for Affinity Health Plan (a Medicaid plan) and HealthSource/Hudson Health Plan were not available in Quality Compass.
- The HEDIS average presented is for the entire state of New York as calculated in Quality Compass.
- Because the partnership only targeted Westchester County, there are no comparable HEDIS rates for the same geographic area. The HEDIS averages for the state of New York are presented instead; however, this rate includes health plans that either do not participate in the partnership or do not provide services in Westchester County.

HEMOGLOBIN A1C—TESTING

Quality Compass	2001	2002	2003
National Mean (%)	78.42	81.39	82.58
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	79.23	81.94	82.06
Aetna-Kansas City	80.79	80.79	82.09
United Healthcare-Midwest	71.78	73.97	77.86
Westchester County, N.Y., Diabetes Coalition			
New York State Average	80.44	83.16	83.66
Aetna N.Y.	72.69	82.84	76.77
Health Net of N.Y.	NR	74.13	78.39
HIP New York	80.78	82.24	83.21
Oxford Health Plans	74.52	81.67	79.86
United Healthcare of N.Y.	73.48	76.87	74.7

HEMOGLOBIN A1C—TESTING

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	66.38	76.58	74.91

POOR HEMOGLOBIN A1C CONTROL (LOWER IS BETTER)

Quality Compass	2001	2002	2003
National Mean (%)	42.52	36.86	33.92
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	52.63	44.6	35.82
Aetna-Kansas City	38.66	38.66	31.86
United Healthcare-Midwest	61.56	62.04	37.71
Westchester County, N.Y., Diabetes Coalition			
New York State Average	37.57	33.17	31.21
Aetna N.Y.	48.02	39.22	38.5
Health Net of N.Y.	NR	44.06	38.39
HIP New York	39.17	32.6	30.17
Oxford Health Plans	55.71	34.57	37.24
United Healthcare of N.Y.	59.12	46.27	49.88

POOR HEMOGLOBIN A1C CONTROL (LOWER IS BETTER)

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	63.57	45.47	44.81

LDL-C SCREENING (LIPID PROFILE)

Quality Compass	2001	2002	2003
National Mean (%)	76.52	81.39	85.14
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	73.83	76.14	80.93
Aetna-Kansas City	71.99	71.99	83.95
United Healthcare-Midwest	67.4	72.02	83.7
Westchester County, N.Y.			
New York State Average	82.29	85.37	89.34
Aetna N.Y.	79.96	79.96	87.7
Health Net of N.Y.	NR	85.08	91.95
HIP New York	86.86	86.86	91
Oxford Health Plans	87.86	90.49	90.63
United Healthcare of N.Y.	82.73	86.32	86.13

LDL-C SCREENING (LIPID PROFILE)

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	61.29	72.9	75.65

LDL-C CONTROLLED (LIPID CONTROL)

Quality Compass	2001	2002	2003
National Mean (%)	44.27	49.77	54.82
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	36.37	43.33	51.65
Aetna-Kansas City	41.2	41.2	56.05
United Healthcare-Midwest	20.68	28.47	57.91
Westchester County, N.Y.			
New York State Average	49.6	53.71	59.08
Aetna N.Y.	42.29	42.29	53.08
Health Net of N.Y.	NR	44.29	55.63
HIP New York	61.56	61.56	57.42
Oxford Health Plans	46.19	51.74	56.91
United Healthcare of N.Y.	34.79	43.03	41.61

LDL-C CONTROLLED (LIPID CONTROL)

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	29.8	47.96	50.77

MONITORING DIABETIC NEPHROPATHY

Quality Compass	2001	2002	2003
National Mean (%)	41.35	46.3	51.82
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	45.88	45.34	46.64
Aetna-Kansas City	37.5	37.5	50.23
United Healthcare-Midwest	41.36	28.71	54.5
Westchester County, N.Y.			
New York State Average	43.14	46.85	54.18
Aetna N.Y.	46.92	46.92	50.34
Health Net of N.Y.	NR	54.78	54.48
HIP New York	53.53	53.53	65.21
Oxford Health Plans	51.67	45.24	51.29
United Healthcare of N.Y.	32.12	42.79	45.01

MONITORING DIABETIC NEPHROPATHY

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	38.26	46.98	48.11

EYE EXAMS FOR PEOPLE WITH DIABETES

Quality Compass	2001	2002	2003
National Mean (%)	48.07	51.99	51.71
Kansas City Diabetes Collaborative			
Kansas City Metropolitan Area Average	44.05	47.65	44.41
Aetna-Kansas City	48.61	58.72	47.91
United Healthcare-Midwest	43.07	44.28	51.34
Westchester County, N.Y.			
New York State Average	55.27	57.78	56.09
Aetna N.Y.	48.68	52.45	48.29
Health Net of N.Y.	NR	51.05	54.94
HIP New York	77.86	77.86	51.82
Oxford Health Plans	56.67	56.61	56.67
United Healthcare of N.Y.	42.09	49.25	45.26

EYE EXAMS FOR PEOPLE WITH DIABETES

New Mexico Health Care Takes on Diabetes Coalition HEDIS Data	2001	2002	2003
Overall N.M. Statewide HEDIS Measures	45.35	51.9	50.77

NOTES

¹ NCQA Benchmarks, 2000.

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⁴ K. J. Devers, "How Will We Know 'Good' Qualitative Research When We See It? Beginning The Dialogue in Health Services Research," *Health Services Research* 34 (December 1999): 1153–88.

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¹⁸ W. M. Hageman, H. S. Zuckerman, J. A. Weiner et al., "Navigating the Rapids of Collaborative Governance," *Healthcare Forum Journal* 41 (March/April 1998): 47–52.

¹⁹ C. Oliver, "Strategic Responses to Institutional Processes," *Academy of Management Review* 16 (1991): 145–79.

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²¹ Area Resource File. Available for purchase from Quality Resource Systems, Inc., 11350 Random Hills Road, Suite 100, Fairfax, VA 22030-6044.

²² <http://www.census.gov>.

²³ InterStudy Publications (Waltham, Mass.: Decision Resources).

²⁴ The IHS HealthGroup, <http://www.medicaldata.com>.

²⁵ <http://www.statehealthfacts.kff.org>.

²⁶ <http://www.americanhealthline.com>.

²⁷ <http://www.cdc.gov/health/diabetes.htm>.

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RELATED PUBLICATIONS

In the list below, items that begin with a publication number can be found on The Commonwealth Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#773 *Will Consumer-Directed Health Care Improve System Performance?* (August 2004). Karen Davis. In this issue brief, based on commentary in the July 2004 issue of *Health Services Research*, the Fund's president argues that consumer-directed plans' high deductibles and out-of-pocket costs can prevent patients from receiving necessary and effective care, potentially costing the health care system more in the long run.

#751 *Achieving a New Standard in Primary Care for Low-Income Populations: Case Studies of Redesign and Change Through a Learning Collaborative* (August 2004). Pamela Gordon and Matthew Chin. According to this report's authors, dozens of New York clinics have cut their waiting times and improved their finances through collaborative learning and an ongoing commitment to change. The report presents case studies of learning collaboratives undertaken at four New York community health centers to improve the delivery of patient care.

#731 *Recommendations for Improving the Quality of Physician Directory Information on the Internet* (August 2004). Linda Shelton, Laura Aiuppa, and Phyllis Torda. According to the authors, millions of Americans rely on the Internet for health information, and most health insurance plans have made their physician directories available online. But physician directories on the Web are often missing key data or contain inaccurate or outdated information.

#767 *Exploring the Business Case for Improving the Quality of Health Care for Children* (July/August 2004). Charles Homer, Debra Iles, Denise Dougherty, Foster C. Gesten, Paul Kurtin, Sheila Leatherman, James M. Perrin, Michael Schoenbaum, Stephen C. Schoenbaum, and Lisa Simpson. *Health Affairs*, vol. 23, no. 4 (*In the Literature* summary). Until recently, discussion of creating a business case for improving health care quality focused solely on adults. In this article, members of the Child Health Business Case Working Group considered the unique features of children's health care and strive to make the business case.

#768 *Overcoming Barriers to Adopting and Implementing Computerized Physician Order Entry Systems in U.S. Hospitals* (July/August 2004). Eric G. Poon, David Blumenthal, Tonushree Jaggi, Melissa M. Honour, David W. Bates and Rainu Kaushal. *Health Affairs*, vol. 23, no. 4 (*In the Literature* summary). According to this article, computerized physician order entry (CPOE) systems can reduce the incidence of serious medication errors by 55 percent, but only 10 percent to 15 percent of hospitals use them.

#761 *Hospital Quality: Ingredients for Success—Overview and Lessons Learned* (July 2004). Jack A. Meyer, Sharon Silow-Carroll, Todd Kutyla, Larry S. Stepnick, and Lise S. Rybowski. This research study identifies and describes the key factors that contributed to the success of four high-performing hospitals across the country. Essential elements of a successful strategy, according to the authors, include developing the right culture, attracting and retaining the right people, devising and updating the right in-house processes, and giving staff the right tools to do the job.

#700 *Quality of Health Care for Children and Adolescents: A Chartbook* (April 2004). Sheila Leatherman and Douglas McCarthy. The researchers use 40 charts and analyses to outline the

current state of children's health care, arguing that the health care system has devoted far less attention to measuring the quality of care for children and adolescents than it has for adults.

#703 *Achieving a High Performance Health System* (January 2004). Karen Davis. In this essay—a reprint of the president's message from the Fund's *2003 Annual Report*—the author argues that what Americans want is not the cheapest health care but the best care, plus clear information and access to care when they need it.

#701 *Physician–Citizens—Public Roles and Professional Obligations* (January 7, 2004). Russell L. Gruen, Steven D. Pearson, and Troyen A. Brennan. *Journal of the American Medical Association*, vol. 291, no. 1 (*In the Literature* summary). This article creates a framework for discussing physicians' public engagement and attempts to bridge the gap between the rhetoric of social responsibility and the realities of medical practice.

#699 *Malpractice Reform Must Include Steps to Prevent Medical Injury* (January 6, 2004). Stephen C. Schoenbaum and Randall M. Bovbjerg. *Annals of Internal Medicine*, vol. 140, no. 1 (*In the Literature* summary). According to the authors, reducing medical injury is essential to solving the current medical malpractice crisis, and physicians must play an active role in developing and implementing systems to improve patient safety.

