RHP18 Learning Collaborative Charter Adopted 8 October 2014

I. Description of RHP18 and the Learning Collaborative

RHP18 is comprised of three counties, Collin, Grayson and Rockwall that together include seven healthcare providers that participate in the Texas 1115Medicaid Transformation Waiver Delivery System Reform Incentive Payment projects (the waiver; DSRIP projects).

As participants in the transformation of the way healthcare is delivered in its three counties, RHP18 PPOs and key stakeholders participate in a Learning Collaborative (LC) to facilitate learning that promotes improvements and the accomplishments of the DSRIP projects' goals.

The LC is the responsibility of the Anchor entity as reflected in the approved LC plan submitted to the Texas Health and Human Services Commission in October 2013.

II. Mission and Vision

LC activities are directed at promoting and supporting the participating performing providers in Collin, Grayson and Rockwall Counties to develop and sustain the characteristics of high-performing health systems based on the Commonwealth Fund Commission on a High-Performance Health System. (Reference attached: DOI: 10.1111/j.1475-6773.2006.00617.x)

The vision of RHP18 is:

By 2016, the healthcare system in RHP 18, will exhibit characteristics of true transformation in its Medicaid health and behavioral healthcare systems. RHP 18 will provide seamless and timely access to a range of evidence-based health and medical services of such quantity and quality that will promote optimum outcomes for its eligible residents.

This Medicaid health and behavioral healthcare system will be interconnected across innovative models with multiple levels of appropriate care. Together, the healthcare providers in RHP 18 will deliver consumer health education, encourage the appropriate use of primary care and prevention, facilitate early intervention, provide advocacy, and ensure follow-up while protecting individual choice and privacy, and the public health and safety of the community.

III. Purpose of the Charter

This Charter provides for

1. Formal representation of RHP18 PPOs and key stakeholders in the LC and QI process associated with the waiver DSRIP projects in RHP18;
2. A methodology and structure for the conduct and participation in LC and RHP-wide QI activities;
3. The promotion of learning, expansion, and improvements in the healthcare delivery system in RHP18 through effective communication, cooperation and synergy among the PPOs and key stakeholders;
4. Dissemination of findings of QI and LC activities;

IV. Purpose of the Learning Collaborative

Learning Collaborative activities are conducted to

1. Directly link front-line providers with patient-centered Quality Improvement (QI) resources and tools, ensuring that QI teams have appropriate tools and training to ensure success in the QI process;
2. Promote RHP-wide improvements through data-driven decision making and promote the benefits of a interprofessional experiences;
3. Sustain a value-driven framework for QI and LC activities that includes:
    a. Seamless, simple, and timely access to evidence-based and innovative healthcare that improves health status and prevents unnecessary emergency and inpatient care;
    b. Patient-centered linkages across multiple providers and multiple levels of integrated care that are the right mix of services at the right time, with pro-active outreach, health education, and follow up while protecting individual choice and privacy;
4. Periodically evaluate the content and quality of interactions among the LC participants, and the Anchor and the RHP18 PPOs;
5. Promote an enduring network of synergistic QI teams that continuously improve the healthcare system in RHP18, and achieve targeted population health outcomes.

V. Model

RHP 18 will rely on the Institute for Healthcare Improvement (IHI) as the primary source of inspiration, methodology, learning and guidance for the LC operating framework.

Under the leadership of the Anchor Team, the LC will incorporate portions of IHI model and effectively develop local expertise in QI processes.

Recognizing that research data are limited regarding the effectiveness of existing models, we will continue to search the literature for characteristics and elements of the most effective models. At this time however, we will focus on the macro level of an RHP-wide initiative, taking a practical approach as described below.

First, we will coordinate, cooperate, and participate in LCs with other RHPs to avoid duplication of effort and to promote effective learning partnerships, both broad and specific.

Second, we will receive, review, reject or endorse topics and tools/methodologies for QI teams to address beginning with the list of QI questions and topics included in this charter.

Third, we will receive, review, respond to, and appropriately disseminate QI team reports.

VI. Structure and Function

The Executive Committee (Exec Cmte) consists of the seven PPO CEOs or their alternates and representatives of the key provider organizations with which they work in their projects.

The Exec Cmte has broad ranging functions as it represents all DSRIP providers in Collin, Grayson, and Rockwall Counties, and the Health Departments in Collin and Grayson Counties. The following four functions are essential, but are not the only functions this Exec Cmte may perform.

1) Work cooperatively with the RHP18 Anchor Team on all aspects of the LC and QI activities;

2) Establish, support, and provide reports from DSRIP project quality improvement teams within each member's respective agency to support the broader aims of RHP-wide initiatives for healthcare innovation and improvement;

3) Guide the topics and initiatives of the Learning Collaborative events; and

4) Facilitate the creation of reports for the Anchor regarding RHP-wide conditions and outcomes associated with DSRIP, UC, and related Medicaid waiver program activities.

Inasmuch as RHP 18 is comparatively small and has providers that have similar/same projects in contiguous or remote other RHPs, leadership is centralized in the RHP 18 Anchor Team consisting of Drs. Hornsby, Cruser, and Coggin. Dr. Cruser has the lead role for the LC activities. The Anchor Team reports to the Collin County Judge as Collin County is the designated and approved Anchor entity, and works with and periodically reports to Grayson and Rockwall counties.

The Anchor Team will be available to assist QI teams routinely and consistently during the first DY cycle, and periodically in later cycles, allowing them to become more independently functional in later years of the projects. As part of the QI process, all PPOs will utilize DSRIP Tracker to report project management data for producing a quarterly RHP18 management report for the Anchor's review.

VII. Authorities

This LC will conduct its work under the authority of the approved LC plan submitted to the Texas Health and Human Services Commission October 2013, herein summarized.

The Executive Committee may establish or request PPOs to establish QI teams to address a topic or question directed at healthcare system improvement within the context of the RHP18 DSRIP plan, including all Categories of projects.

QI Questions and Topics endorsed October 2014 for content in RHP18 Learning Collaborative events – subject to revision at subsequent LC events and Executive Committee meetings. Questions and topics are directed at developing an outline of the "ideal healthcare system" for RHP18, and preparing for possible application for renewal of the Medicaid Waiver program.

DY4

- Identify gaps in the RHP18 healthcare system as illuminated by the current DSRIP projects, for low income – uninsured or underinsured and Medicare clients, and the Texas population covered by Medicaid? This information may be utilized for planning DSRIP projects beyond the year 2016. The November Learning Collaborative event will be dedicated to starting this gap analysis, with continued reviews and updates through DY4.
- What strategies have RHP18 providers used for patient education to change behaviors in self-care, dependence on the ER, or other targeted health system improvements? This will be one of the topics at the January 2015 Learning Collaborative event.
- What are other RHPs doing in the area of Health Information Exchange systems, tracking RHP-wide health care indicators and targeted PPAs from which RHP18 can learn or benefit, and what do the data from Category 4 projects indicate regarding PPAs? This is tentatively set as a topic for the March 2015 Learning Collaborative event.
- What results from the Category 3 outcome measures projects (methods and data in DY2) demonstrate improved health status, and how can these data be used to improve existing or create new or expanded DSRIP projects? The May Learning Collaborative event will include reports from providers on quality of life and patient satisfaction surveys.
- What has RHP18 learned as a total system of care from the challenges and innovations addressed in DY3, and in the first half of DY4 (October 1, 2013 through March 2015)? This will be one of the topics for the July 2015 Learning Collaborative event.
- What is the level of activity, success, and challenges in interagency referrals for DSRIP clients – as the DY4 Raise-the-Floor activity? This is tentatively set as a topic for the September 2015 Learning Collaborative event.

DY5

- What is the most plausible outline of the "ideal healthcare system" for RHP18 for low-income uninsured, underinsured, Medicare, and Medicaid populations?
- Are Medical Home models being adopted in RHP18 and to what extent with what outcomes?
- Is there evidence of customized care plans, telemedicine, or other DSRIP projects reducing unnecessary incarceration, hospitalization or use of emergency services?
- What data are available on the impact/contribution of patient navigation projects in RHP18?

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Commentary

Commentary—Achieving a High-Performance Health System: High Reliability Organizations within a Broader Agenda

Anne K. Gauthier, Karen Davis, and Stephen C. Schoenbaum

Striving for a High-Performance Health System in the United States

Despite a tradition of innovation and a "can-do" attitude among Americans, the performance of our health care system falls considerably short of where it could be. The United States spends more on health care than any other country, but fails to provide universal access to care, use its resources efficiently, or achieve value for money spent (Frogner and Anderson 2006). Americans do not live as long as citizens of major industrialized nations, and there are widespread disparities based on insurance status, income, race, and ethnicity (Gauthier and Serber 2005). More than one-third of the population is uninsured, unstably insured, or underinsured (Schoen et al. 2005). There are also significant lapses in safety, with as many as 98,000 Americans dying from medical errors each year (Kohn, Corrigan, and Donaldson 2000). And patients receive only 55 percent of recommended care (McGlynn et al. 2003).

At the same time, there are examples within the United States of high performance on coverage, access, quality, and efficiency of care (Gauthier and Serber 2005; Gauthier, Schoenbaum, and Weinbaum 2006). But diffusion of such best practices is slow at best. Getting better results quickly will require a major transformation of the health financing and delivery system. Such a transformation requires first that each component health care organization independently has excellent performance. This is not a sufficient condition, as these organizations, from small physician practices to hospitals to health plans to nursing homes and more, need to be tied together into a coordinated "system" of care. Similarly, for each component organization to achieve high

performance, high reliability in delivering care is a necessary but not sufficient condition. The promising work on high reliability organizations is one building block of a broader transformation.

In this paper, we lay out 10 dimensions that define a high-performance health system and discuss some specific changes needed to get there. In that context, we discuss the role of organizations striving for high reliability and their contribution to the system we seek to attain, as well as the roles for government and private foundations. Given our foundation vantage point, we review the role of foundations in setting the agenda and describe an exciting new effort by The Commonwealth Fund to align and speed the pace of change with the establishment of a Commission on a High-Performance Health System.

What Changes Are Needed to Achieve a High Performing U.S. Health System?

The Commonwealth Fund's Commission on a High-Performance Health System defines the characteristics of a high-performance system across 10 dimensions:

- The overarching goal of ensuring that everyone lives as long, healthy, and productive lives as possible is met.
- Patients get the right care known to be effective, for prevention, treatment, or palliation; underuse, overuse, and misuse are absent.
- Patients receive coordinated care over time, with an advanced primary care practice or medical home responsible and accountable for care for every person.
- The care provided is safe care, from organizations specifically trained to minimize errors—high reliability organizations.
- Care is patient-centered provided in a timely way with service excellence.
- The system provides care that is the highest value for the money spent and is efficiently delivered.

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- Care is affordable from the patient's and payer's perspective.
- There is universal participation in the system.
- Care is provided equitably across race/ethnicity, income, age, sex, and geography.
- The system has the capacity to continuously improve and innovate.

As a nation, we are far from where we can be and want to be on each dimension. While our pluralistic public–private system has numerous strengths, many of the system's current features keep us from achieving the dimensions of high performance. Major change is needed; however, even the smallest changes are challenged by the absence of public–private collaboration in developing operational principles, inadequate information on performance at the provider level, and misaligned incentives for providers and patients. Public policy changes are needed at the federal, state, and local level that facilitate and support innovation and the dissemination of effective practices in the largely private health care delivery system. In short, policy and practice need to work together to support improvement and innovation within the system, so that our quality, efficiency, and access characteristics of performance can be met.

As highlighted in the landmark Institute of Medicine report, *Crossing the Quality Chasm* (IOM 2001), system transformation needs all health care constituencies to commit to a national statement of purpose for the health care system as a whole. We cannot reach high-performance without universal participation; here, public policy must take the lead, and health care delivery organizations play their key role by getting those with coverage the care they need.

Additional changes involve expanded private sector and public sector roles in six key areas.

We need to *enhance the quality and the value of the care provided.* This includes promoting the use of evidence-based medicine, promoting effective chronic care management, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings. Innovations to date in these areas have been largely public–private collaborations, although the investment to date has been limited. Furthering the evidence base is a public good—it can be accomplished through many models, but a national commitment to doing so and to funding it is critical. Health care delivery organizations must make a similar commitment to design the processes to

ensure that effective treatments are provided safely and efficiently and that ineffective or wasteful practices do not occur.

We need to *organize care and information around the patient.* Insurers and providers can promote shared decision making by providing tools to assist with health care decisions (e.g., videotapes, booklets, websites), providing follow-up counseling with skilled staff, requiring shared decision-making education for elective procedures, and making complete personal health records and data accessible to patients and their providers. Purchasers can reward plans that emphasize patient-centered care.

A third area is to *expand primary care and preventive services.* While appropriate specialty care is essential, there is increasing evidence that a high-performance health system needs to focus on primary care. As Starfield and colleagues found (Starfield, Shi, and Macinko 2005), health is better in areas where there are more primary care physicians, and people who receive care from a primary physician are healthier. She concludes that, "a greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population's health." Clearly, purchasers and insurers can affect the provision of primary care through benefits design, but health care delivery organizations can redesign processes and systems to support it as well.

Expanded use of interoperable information technology will also be needed as we attempt to build a higher performing system, although we caution those who see information technology as a quick fix to all health system problems. Computerized order entry systems and electronic health records developed at the organizational level, can help to reduce costs and improve safety and efficiency for individual organizations. In order for the health system to maximize benefits from these systems, however, innovation must focus on linking all of the pieces into an interoperable network. There is a role for the public sector to create incentives to encourage providers to improve health care performance with well-designed information technology that provides decision support and reduces administrative costs. In addition, large purchasers (including the government) can require participating providers to utilize technologies demonstrated to reduce errors and save lives.

We must also ensure that the system is redesigned to *align payment incentives and reward performance.* Our payment system should be restructured so that providers are reimbursed based on the quality of the care they provide. Payment incentives should be aligned to encourage all providers to strive to deliver care that meets the criteria of excellence in quality and efficiency, and to encourage shared accountability for jointly provided care

across the continuum of care and over time. Purchasers (both public and private) can improve quality and efficiency by building performance standards into health plan contracts and developing pay-for-performance programs that reward quality and efficiency in the provision of acute and chronic episodes of care.

Lastly, we must *encourage collaboration among all of the various stakeholders involved in health care financing and delivery.* We must create a culture of high performance, where all parties share a vision of bringing high quality health care to every person in the United States. It is particularly critical to bridge the gap between the public and private sectors and use the strength of these collaborations to maximize system performance. The public sector can subsidize private insurance to expand coverage. The public sector can also use its power as a large purchaser to negotiate better pricing for smaller private purchasers and can set standards for what types of quality and efficiency measures are collected and reported. Private organizations can redesign care processes that work to meet those measures, and both can play a role in disseminating best practices.

High Reliability Organizations—Playing a Critical Role in Improving Performance, But Only a Start

As noted above, for the United States health care system to have high performance, each of its component health care organizations must be excellent, and they must be tied in some way to create a "system" where little exists today. Similarly, for each component organization to achieve high performance, high reliability is a necessary but not sufficient condition.

Much of the focus on high reliability has related to patient safety, and safe care is critical. But it is only one of the 10 dimensions of performance, and as such, achieving a much higher level of safety takes us only part of the way there. Of equal importance, however, is having effective care. More lives are lost each year in the United States from failure to deliver effective care as from medical error (Woolf 2004). Failure to deliver effective care is comprised of errors of omission and commission, i.e., underuse and overuse. Failure to give diabetics appropriate testing and treatment is a failure to deliver effective care. So is the unnecessary insertion of a pacemaker or unnecessary administration of antibiotics.

The principles for achieving high reliability organizations are applicable to achieving effective care as well as safe care. Underlying these approaches is the development and implementation of systems, simplifying complex processes, and having effectively functioning teams. In addition to providing safe and effective care, a high performing organization also must be efficient. Effective and safe care must be provided without wasting resources.

At the present time, there are some high reliability "units" in health care—e.g., some operating room teams; but in truth, there are no entire "high reliability organizations." Shortell et al. (2005) found no "perfect process" group practices across four domains of performance: quality performance, patient satisfaction, organizational learning, and financial performance. The relatively small group of practices that excelled was distinguished particularly by their emphasis on the "importance of a quality-centered culture and the requirement of outside reporting from third party organizations." In turn, a "quality-centered culture" was assessed by the intensity of the group's involvement in quality improvement programs for patients with specific chronic conditions, measurement of patient satisfaction, and compensation of the individual physicians in the group for quality or patient satisfaction.

In a qualitative study, Jack Meyer et al. (2004) interviewed four hospitals that distinguished themselves on two independent assessments of quality and cost. They found that 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 were essential to better performance. There was also an impact of external influences, such as local market competition and public or private health quality initiatives and standards.

Leadership is a key feature of performance improvement and attainment of higher performance. It is needed at all levels of the organization; but the organization as a whole will not perform at a high level without leadership on quality and efficiency at the top. Business survival and stability is important, indeed essential, but organizational leadership that is primarily focused on mergers and acquisitions and market dominance is unlikely to achieve high performance.

But even the best leadership requires a supportive external environment—one that ensures financial stability though universal health insurance coverage and payment systems that reward results. Information on best practices and comparative performance across peer organizations is also essential—and a "public good" function. The public sector can also help facilitate an integrated electronic health information system that brings all of a patient's health information together in one place accessible

Table 1: Roles for High Reliability Organization in Transforming the U.S. Health Care System

Key Changes for Transforming Health Care System	*Role of High Reliability Organizations*
(1) Enhance the quality and value of care	Leadership in process redesign and provision of data to measure improvement
(2) Organize care and information around the patient	Leadership in process redesign
(3) Expand primary care and preventive services	Respond to policy and payers
(4) Expand use of interoperable information technology	Leadership in adoption, but within a broader system context
(5) Align payment incentives and reward performance	Respond to policy and payers
(6) Collaboration among all of the various stakeholders	Leadership in coming to the table; sharing practices

to authorized providers to facilitate safe, effective, patient-centered, and efficient care.

So can the innovator organizations striving for high reliability lead the way to a high performance health system? The answer is that they can lead in developing specific delivery innovations, but the public sector will also need to lead to ensure the transformation that is needed. Table 1 illustrates this point.

The Commonwealth Fund Commission on a High-Performance Health System

Unfortunately, health reform is not currently on the national policy agenda. Historically, private foundations have stepped in when voids in public policy have left major issues unaddressed (Davis 2005). Perhaps the best known of these efforts was the Flexner Commission on the quality of medical education report in 1910.

The turn of a new century should have been an opportunity for fresh thinking and solutions to problems vexing the U.S. health system. Numerous efforts throughout the 20th century to achieve universal health insurance coverage, for example, came to naught but afforded ample lessons on the obstacles to change and promising strategies for the future (Davis 2001). Instead, gridlock and deeply partisan divisions at the federal level and inadequate financial capacity at the state level have stymied reform efforts. Instead further fragmentation of the health system has occurred.

Clear deterioration in health system performance (increase in the uninsured, increases in costs, and increased recognition of quality problems) has contributed to a decision by The Commonwealth Fund to integrate its work to focus on health system change. To address the increasing urgency of rising health care costs and the need for greater efficiency in the delivery of health care services, The Commonwealth Fund board of directors established the Commission on a High Performance Health System in July 2005. The Commission's goal is to move the nation toward a health care system that provides better access, higher quality, and greater efficiency, with particular focus on the most vulnerable members of our society. The specific objectives of the Commission are to define the characteristics of a high-performance health system; identify and analyze promising approaches being used across the country and around the world; set benchmarks and realistic targets for tracking change over time; and recommend immediate and long-term practical steps and policy measures. The Comission's first task has been to define a framework to organize the multiple public and private financing and delivery mechanism involved in U.S. health care into a more cohesive "system." The second major effort is an annual scorecard which will track the performance of the U.S. health care system along the ten dimensions of high performance described earlier (pp. 1711–12). The scorecard will begin with a clear picture of each dimension, showing that we are far from where we could be when we look across the nation and to other countries. A companion state scorecard will help each state understand strengths and weaknesses and develop concrete steps for improvements. The scorecard will establish benchmarks of current best practice and realistic targets for future improvement. By focusing on our 10 key dimensions and by clearly showing what can be attained in each, we anticipate that the case for policy and practice change will be compelling to those who are not yet convinced of the need for significant change.

The Commission will also benefit from the views of health care leaders across the health care system in fashioning recommendations. In periodic surveys of health care opinion leaders across the health care sector—from academia and research institutions, health care delivery organizations, health insurance companies, pharmaceutical and other health industries, consumer advocacy organizations, labor, and government—The Commonwealth Fund has found remarkable consensus on policy strategies that are most promising. To expand health insurance coverage, they recommend letting small businesses and individuals buy coverage through the Federal Employees Health Benefit Plan, giving incentives to employers to expand coverage, providing tax credits or other subsidies to low-wage workers, requiring employers to

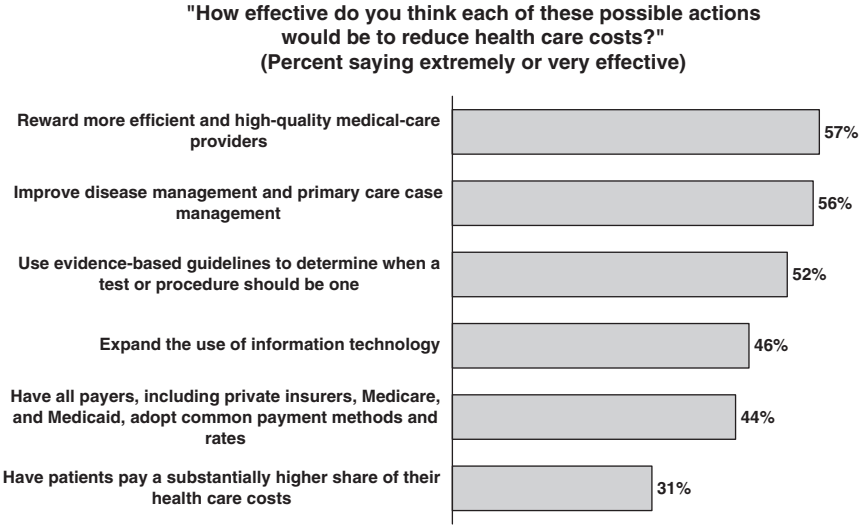
contribute to a fund if they do not provide coverage, and providing federal matching funds for expansion of Medicaid and the Children's Health Insurance Program to everyone below 150 percent of the federal poverty level (The Commonwealth Fund 2005b).

To tackle the issues of quality and health care costs, they recommend rewarding more efficient and high-quality medical care providers, improving disease management and primary care case management, using evidence-based guidelines to determine when a test or procedure should be done, expanding the use of information technology, and having all payers (including private insurers, Medicare, and Medicaid) adopt common payment methods and rates (The Commonwealth Fund 2005a) (Chart 1).

CONCLUDING THOUGHTS

A two-pronged strategy of encouraging the development of high reliability organizations and moving a policy agenda that will support high performance,

Chart 1: Health Care Leaders: Pay-for-Performance Is the Most Effective Way to Reduce Health Care Costs



Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2005.

is needed to achieve the kind of health care system that Americans want and deserve. The Commonwealth Fund Commission on a High-Performance Health System will pursue this strategy by examining policy options and best practices that accomplish the major changes noted earlier. The specific actions recommended will lead to increased accountability and "systemness," in ways that promote continual improvement and innovation. We recognize the challenge, but it is our hope that the Commission's work will be pivotal in moving the nation toward a high-performance health system, one that offers better access, improved quality, and greater efficiency to all Americans.

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REFERENCES

Davis, K. 2001. *Universal Coverage in the United States: Lessons from Experience of the 20th Century.* New York: The Commonwealth Fund.

———. 2005. "Toward a High Performance Health System: New Commonwealth Fund Commission." *Health Affairs* 24 (5): 1356–60.

Frogner, B., and G. Anderson. 2006. *Multinational Comparisons of Health Systems Data, 2005.* New York: The Commonwealth Fund.

Gauthier, A., S. Schoenbaum, and I. Weinbaum. 2006. *Toward a High Performance Health System for the United States.* New York: The Commonwealth Fund.

Gauthier, A., and M. Serber. 2005. *A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency.* New York: The Commonwealth Fund.

Institute of Medicine (IOM), Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press.

Kohn, K., J. Corrigan, and M. Donaldson. 2000. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press.

McGlynn, E., S. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E. Kerr. 2003. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348 (26): 2635–45.

Meyer, J., S. Silow-Carrol, T. Kutyla, L. Stepnick, and L. Rybowski. 2004. *Hospital Quality: Ingredients for Success Hospital Quality: Ingredients for Success—Overview and Lessons Learned.* New York: The Commonwealth Fund.

Schoen, C., M. Doty, S. Collins, and A. Holmgren. 2005. "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs.* Web exclusive. http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.289/DC1.

Shortell, S., J. Schmittdiel, M. Wang, R. Li, R. Gillies, L. Casalino, T. Bodenheimer, and T. Rundall. 2005. "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study." *Medical Care Research and Review* 62 (4): 407–34.

Starfield, B., L. Shi, and J. Macinko. 2005. "Contributions of Primary Care to Health Systems and Health." *Milbank Quarterly* 83 (3): 457–502.

The Commonwealth Fund. 2005a. "The Commonwealth Fund Health Care Opinion Leaders Survey: Assessing Health Care Experts' Views on Health Care Costs." [accessed February 20, 2006]. Available at http://www.cmwf.org/surveys/surveys_show.htm?doc_id=275633

———. 2005b. "The Commonwealth Fund Health Care Opinion Leaders Survey: Assessing Health Care Experts' Views on Health Insurance Issues." [accessed February 20, 2006]. Available at http://www.cmwf.org/surveys/surveys_show.htm?doc_id=263060

Woolf, S. 2004. "Patient Safety Is Not Enough: Targeting Quality Improvements to Optimize the Health of the Population." *Annals of Internal Medicine* 140 (1): 33–6.