

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

North Carolina is renowned for its primary care systems and infrastructure that allows and supports ongoing quality improvement and primary care practice transformation. North Carolina's successes in this area are due largely to its ability to synchronize and align initiatives within the state. The entities there that support transformation of primary care practices have found the benefits of collaboration include better health outcomes, lower cost, and a new way of organizing and improving health in a state.^{1,2,3}

The North Carolina Healthcare Quality Alliance (NCHQA), a non-profit organization comprised of both private and public partners across the state's healthcare system, provides a forum for leaders to work together to improve the quality of care. Through its role as a convener of state leaders, the NCHQA is able to promote and facilitate quality improvement in primary care. This *State Health Policy Briefing* examines the success the NCHQA and its members have had working together to promote and support primary care practice transformation in North Carolina and offers lessons for states interested in pursuing similar goals.

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Briefing

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The North Carolina Healthcare Quality Alliance: Lessons in Aligning Quality Improvement Strategies Statewide

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North Carolina has developed a successful model for primary care practice redesign and ongoing improvement, referred to as primary care transformation. This is a model that other states have expressed interest in adopting or adapting. North Carolina is also one of four states selected for the Agency for Healthcare Research and Quality's Infrastructure for Maintaining Primary Care Transformation (IMPACT) initiative, which aims to support, expand, evaluate, and disseminate leading state-level primary care practice support efforts to transform primary care practices, develop sustainable infrastructure for quality improvement in primary care practices, and serve as potential models for a national primary care extension service.

In order to understand the genesis and evolution of the North Carolina transformation model, and the support and collaboration that have enabled it to succeed, it is necessary to understand the role of the NCHQA. To develop this paper, NASHP interviewed a range of key leaders involved with North Carolina's practice transformation activities. Additionally, these leaders all played a role in the development and subsequent evolution of the NCHQA. Those interviewed include:

- **Alan Hirsch, JD**, President, NCHQA
- **Elizabeth W. Kasper, MSPH**, Project Manager, NCHQA
- **Warren P. Newton, MD, MPH**, Executive Associate Dean for Medical Education, University of North Carolina at Chapel Hill; Chair of the Board of Directors, NCHQA
- **Don Bradley, MD, MHS-CL**, Senior Vice President and Chief Medical Officer, Blue Cross and Blue Shield of North Carolina; Vice Chair of the Board of Directors, NCHQA
- **Tom Bacon, DrPH**, Director, North Carolina Area Health Education Centers; Executive Committee Member of the Board of Directors, NCHQA

These interviews and supporting background documents informed this issue brief, from which other states can derive lessons on leadership and strategies to support primary care practice transformation. The following sections describe the NC HQA's origin and creation, its membership, original goals and initiatives, evolution, and key lessons for states interested in pursuing similar goals.

EARLY PRIMARY CARE PRACTICE TRANSFORMATION IN NORTH CAROLINA

The early success in North Carolina's practice transformation work can be traced to several initiatives and organizations operating in the state: Community Care of North Carolina (CCNC), the North Carolina Area Health Education Centers (NC AHEC), and the Improving Performance in Practice (IPIP) project. These formed the foundation for the NCHQA.

COMMUNITY CARE OF NORTH CAROLINA

CCNC was developed in 1998 by the North Carolina State Office of Rural Health (in cooperation with North Carolina Medicaid) to spread the idea of medical homes for patients enrolled in Medicaid. It has since developed into a public-private partnership, focusing on physician-driven, patient-centered care, bringing together service providers in regional networks including physicians, nurses, pharmacists, hospitals, health departments, social service agencies, and other community organizations. These groups work together through the medical home model to provide cooperative and coordinated care. CCNC provides each enrolled patient with a primary care physician who leads a health care team designed to best address each individual's needs.⁴

CCNC has saved the North Carolina Medicaid program more than \$1 billion since 2003 and has contributed to North Caro-

lina being one of only three states to decrease total Medicaid spending between the fiscal years 2008-2009.^{5,6} Its reach within the state in terms of patients, number of practices and networks, care management techniques, quality improvement initiatives, and informatics center has made the organization a powerful tool for initiating and supporting primary care practice transformation. CCNC's innovative payment structure and contractual obligation with Medicaid has enabled it to manage assigned populations, which also greatly assists primary care practices in their transformation.

THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS

The North Carolina Area Health Education Centers program (NC AHEC) was established in 1972 and is the largest regional health professions network in the country with a budget of more than \$200 million. The NC AHEC works with the state's four academic medical centers, universities, and community colleges and its 20 primary care residency programs have trained more than 2,700 physicians during the past 25 years.⁷ During the past 10 years, the NC AHEC has undertaken a number of educational programs focused on performance improvement, including several large-scale improvement programs, such as management of the Improving Performance in Practice (IPIP, see below) program. The NC AHEC has essentially developed a large-scale practice coaching and improvement network program.

The NC AHEC was also selected by the Office of the National Coordinator for Health Information Technology (ONC) to be the Regional Extension Center for North Carolina to assist the state's primary care practices to implement electronic health records.⁸ The NC AHEC's partnership with the academic medical centers, its role in implementing practice improvement projects, and its status as a Regional Extension Center also make it a valuable support for primary care practice transformation.

THE IMPROVING PERFORMANCE IN PRACTICE (IPIP) PROJECT

The NC Improving Performance in Practice (NC IPIP) project was created by a steering committee of many leaders across the North Carolina healthcare system and represented key quality improvement leaders both in the state and nationally. NC IPIP was originally administered by the North Carolina Academy of Family Physicians and initially funded by a grant through the Robert Wood Johnson Foundation, with the goal to improve the quality of primary care in all primary-care practices across

entire states.⁹ Both North Carolina and Colorado were chosen for the initial project, focusing on diabetes and asthma.¹⁰ The project used many strategies from prior quality-improvement initiatives, including the Chronic Care Model, which provided the basis for change in individual practices and emphasized several vital aspects for improvement. These strategies included national measures, registries to provide information at the point of care, decision support tools, self-management support, protocols to standardize care, learning networks of practices and quality improvement consultants.¹¹

THE CREATION OF NCHQA

The North Carolina Healthcare Quality Alliance (NCHQA) developed as the result of a number of converging and complementary goals and initiatives in the state. The NCHQA was established in 2006 as the Governor's Quality Initiative (GQI).¹² The original impetus for the GQI was a desire within the governor's office to initiate a statewide focus on quality improvement in primary care, similar to the state's 100,000 Lives Campaign that focused on quality improvement in inpatient care.¹³ The state sought to translate lessons from the 100,000 Lives Campaign to primary care practice transformation.

The success of existing initiatives put North Carolina in a unique position; the state had two large organizations, CCNC and NC AHEC, ready to support practices and spread innovation. North Carolina IPIP was up and running with improvement support for practices. North Carolina AHEC and CCNC had established a strong partnership around the NC IPIP pilot and were ideal partners to expand the goals and spread the reach of NC IPIP, given extensive networks, infrastructure, community-based strategies, and a practice improvement support system. State leaders realized the benefit in aligning work and decided to develop an entity capable of taking a statewide approach; one that would include existing private and public stakeholders, including private payers.

The Governor's Quality Initiative (GQI) was originally an informal collaborative; each of the players saw the benefit of working together and began to consider how to align initiatives to more broadly spread primary care practice transformation. The governor's office was able to bring private payers into the partnership, in particular Blue Cross and Blue Shield of North Carolina, the state's dominant insurer, and the idea of formalizing a high-level alliance began to develop. The governor's office convened the major healthcare stakeholders in the state—

health care providers, insurers, and employers—to form the GQI.

Despite the common goals of CCNC and NC AHEC, leaders in the state note that integration of the two organizations took many meetings to develop trust, consensus related to interventions, metrics and financing.¹⁴ As the Governor's term drew to a close in January 2009 the group decided – given an unknown level of support by the incoming Governor– to form as a non-profit and the GQI transitioned to NCHQA.

ORIGINAL GOALS AND ACTIVITIES

The original mission of the NCHQA was to provide a forum for all of the major players (state government, insurers, providers, patients, etc.) in North Carolina to come together to collaborate on improving health care for North Carolinians through promotion of evidence-based primary care. The original members also wanted to create a forum insulated from the pressures and politics of state government where these groups could have frank discussions about state health system issues. This increased the desire to be an independent body, so that these conversations could occur and trust could grow amongst the partners.

Primary care improvement was the NCHQA's first initiative. The nature of NCHQA made it a natural ally/supporter of the NC IPIP project mentioned above. Tom Bacon, Program Director of the NC AHEC, noted that the NCHQA played a vital role in the project and contributed in some significant ways, including “giving legitimacy at the highest levels of state government to what we were doing; serving as a convener of all the key constituencies involved in QI; and third, bringing the largest insurer to the table, with major funding for these collective efforts.” As the project developed further, the NC AHEC took the lead in hiring Quality Improvement Coaches (QICs) to work with practices to implement the expanded NC IPIP, and the NCHQA began to serve as an advisory and advocacy body, taking over these activities from the steering committee that created NC IPIP.

The NCHQA would also eventually play a critical role in NC IPIP's funding, which drew on multiple sources. In the early years of the project, NC IPIP was funded primarily through the Robert Wood Johnson Foundation grant, North Carolina Division of Public Health, and North Carolina Division of Medical Assistance (state Medicaid agency) funding. The NC AHEC also received appropriations from the state legislature, which

became the largest source of funding for NC IPIP. However, as the state budget grew tighter, funding from NCHQA became key to continue the project. The NCHQA was able to raise money from Blue Cross and Blue Shield of North Carolina, which invested \$2 million; an additional \$1 million came from North Carolina's share of the Tobacco Master Settlement Agreement, and smaller grants came from the National Governors Association and the Center for Health Care Strategies.¹⁵ Funds were matched by federal Medicaid dollars when appropriate. The NCHQA funded incentive payments for practices, registry software and some general operating support for QIC salaries. As a result of this support, NC IPIP was able to grow from less than 20 practices to 180.

The North Carolina Healthcare Quality Alliance not only provided critical support for NC IPIP, but also coordinated and aligned a number of quality initiatives happening concurrently across North Carolina's healthcare system. Standing committees included one focused on quality measures, another on practice support and communications, and a third that serves as a clinician's advisory group.¹⁶ The NCHQA found agreement on a single set of quality measures based on nationally recognized standards in five costly and common chronic diseases: diabetes, asthma, congestive heart failure, hypertension, and post-myocardial infarction care. The NCHQA also initially pursued plans to build a state data warehouse to capture healthcare quality information. However, due to health information technology measures included in federal healthcare reform legislation, NCHQA decided building a stand-alone data warehouse was no longer the best course of action.

NCHQA'S GROWTH AND EVOLUTION

The North Carolina Healthcare Quality Alliance is governed by a board of directors comprised of representatives of the North Carolina Hospital Association, Blue Cross and Blue Shield of North Carolina, the North Carolina Area Health Education Centers (NC AHEC) program, Community Care of North Carolina (CCNC), the North Carolina Division of Medical Assistance, and the North Carolina Division of Public Health, among others.¹⁷ The organizations represented, and the seniority of the representatives within their organizations, effectively serves to make the board of NCHQA a composite of all of the key partners across health sectors within the state. The value of NCHQA lies in part in its voluntary membership. The participation of these partners allows NCHQA and its board to act as a forum in which all groups can raise issues and

work together. This collaborative environment allows NCHQA leadership to craft initiatives that no one entity can accomplish singlehandedly.

With the growth of NC IPIP and other quality initiatives, NCHQA has begun to consider how to continue to best align the work of its partners. The passage of the Affordable Care Act has also provided NCHQA with new avenues for potential improvements in quality and practice transformation.

TRANSITION OF NC IPIP TO NC AHEC

The NC AHEC, given its role of hiring the QICs, as well as being one of the principle funders, became the de facto manager of NC IPIP and eventually the project completely transitioned to the NC AHEC from the NC Academy of Family Physicians. North Carolina AHEC has since continued to develop and support the program. Members of NCHQA noted that given NC AHEC's infrastructure for practice support—including its role as the regional extension center—it was the logical landing place for the NC IPIP program, enabling NC AHEC to offer a comprehensive and seamless set of services for primary care practices.

North Carolina IPIP has since developed a strategy to spread its activities to new practices via word of mouth about what NC AHEC can offer via NC IPIP.¹⁸ The NCHQA continues as an advocacy and advisory body for the project, roles it assumed from the steering committee that created the project. North Carolina estimates that it now has more than 1,000 practices undertaking NC IPIP practice improvement activities on some level, which comprises almost 50 percent of the state's practices.

Representatives of NC AHEC note that these impressive results are the product of the broad support the project received, particularly in its early years, and the high levels of funding it received from the legislature, partner agencies, and the NCHQA. According to Tom Bacon, NC AHEC Program Director, the NCHQA has "been fortunate to have resources at key times to take great ideas to scale. CCNC is a good example where a few legislative leaders agreed to give it a try, put real money into it, and then fended off efforts to kill it until it could truly demonstrate results. AHEC also has seen similar good fortune [...]" The fact that NCHQA reaches such a broad and high level of both public and private health system leadership within the state made it a critical partner in achieving both support and funding to get the project to where it is today.

BROADENING OF GOALS AND SCOPE OF ACTIVITIES

The North Carolina Health Care Quality Alliance's focus is now on the crosscutting issues of health care quality. The NCHQA is particularly interested in the opportunities to advance quality improvement or expand coverage that are presented through passage of the Affordable Care Act. Board members of NCHQA also note that because NCHQA does not deliver care or provide coverage to patients, as many of its partners do, it is able to focus on synergies and creating a comprehensive system of care. This allows NCHQA to act proactively on burgeoning quality initiatives without some of the day-to-day challenges of its member associations. In addition to broadening its goals, the NCHQA has now begun to broaden its scope of activities as well.

CURRENT GOALS AND INITIATIVES

As a result of federal health reform legislation and the growth of NC IPIP, NCHQA broadened its scope and established three new core goals:

1. Provide leadership for the improvement of health care delivery in North Carolina.
2. Promote and facilitate transparency and public accountability.
3. Foster innovative and sustainable activities and interventions that improve the quality and value of health care.¹⁹

The NCHQA's new goals reflect the organization's shift away from a sole focus on primary care transformation to a broader focus on health system transformation and redesign, including inpatient and specialty care in addition to primary care. The NCHQA's current projects reflect this shift in focus:

- multi-payer projects that are designed to lead, support, and encourage integrated/coordinated care;
- a transitions-based initiative, aimed at reducing readmissions and improving the overall quality of care across providers; NCHQA is collaborating with primary care physicians, specialists, hospitals, CCNC and others;
- a transparency initiative to develop common quality reporting standards among stakeholders across North Carolina.²⁰

LESSONS AND STRATEGIES FOR SUCCESS

The North Carolina Healthcare Quality Alliance did not create a new partnership among leaders, but instead formalized a process/partnership already in place. This distinction is important as it reinforces the benefit of building similar efforts off of existing partnerships. All members of NCHQA interviewed were careful to point out that many of the relationships and partnerships between high-level leaders in the North Carolina health system were already established. Many were informal, and the collaborative nature of leadership within the state developed over time. There are various explanations for why this collaborative nature exists in North Carolina; one is that the culture promotes it. Another is that the high level leaders have often served in different roles across agencies (i.e. the current head of CCNC previously served as the state Medicaid Director), and are aware of the demands facing the other leaders and their organizations. Another is that the leaders who are engaged are transformative in their thinking. According to key partners:

- "There is an important contribution of leadership at the early phases." – Warren Newton, MD, MPH, Vice Dean of Education, and Chair, Department of Family Medicine, University of North Carolina at Chapel Hill; Chair of the Board of Directors, NCHQA
- "It wasn't one person or even a few people. It was many people across many sectors that needed to support this coming together over a couple decades. But it wasn't just luck. There was strategy and that strategy seemed to rub off on new people as they came in. It required a lot of commitment to stay in the game. It may have been easier to walk away at several junctures." – Darren DeWalt, MD, MPH, Associate Professor of Medicine, University of North Carolina at Chapel Hill
- "You have to convince the leadership of various organizations that their participation will make an important long term difference... You must find the person in the organization that is visionary." – Alan Hirsch, JD, President, NCHQA

Regardless of the genesis of this collaborative history, the leaders who serve on the board of the NCHQA all agree the process takes time to develop, but that there is no reason this level of partnership cannot occur outside of North Carolina. The NCHQA, therefore, offers many lessons and strategies for states looking to align health care quality initiatives, including primary care transformation.

- **Develop a platform for cross-initiative collaboration outside of the on-the-ground, day-to-day efforts of the partners.** One aspect that makes NCHQA so valuable is its provision of a space where partners can reflect on and look for opportunities for cross-system development and collaboration. The NCHQA is then able to coalesce partners to drive these changes forward.
- **Provide a neutral forum for leaders to address high-level, often sensitive policy issues, such as transparency and competition.** This serves to build trust and partner engagement. The variety of public and private stakeholders who represent provider groups, insurers, and purchasers ensures that discussions consider the interests and points of view of all those involved in the health system. Given that these groups often differ on issues, disagreements will inevitably arise; operating in a transparent environment ensures that stakeholders focus on the best interests of patients first and hash out their differences from this perspective. Overall, those involved with NCHQA note that having access to this forum has built a true sense of collaboration and a shared sense of purpose.
- **Choose leaders carefully.** When developing a body like NCHQA, it is critical to engage the appropriate leaders. Some strategy is necessary to reach leaders who are transformative and prepared to be innovative. North Carolina was able to identify visionary leaders in the state and bring them together.
- **Engage multiple funders to help spread quality improvement efforts.** As mentioned above, NCHQA was able to use its statewide reach to acquire funds from a number of sources. The state funds have since ceased as the economy changed, but the nature of the NCHQA as an organization that reaches across the spectrum of the health system stakeholders in North Carolina ensures that a number of different groups are and will remain invested in it.
- **Carefully weigh the benefits of forming an organization that sits within state government versus forming as a non-profit organization.** The Governor's office played an integral role in convening the original players that would eventually form the NCHQA. Several members of the NCHQA board noted that the state's role was critical at the inception. These members also noted, however, that the plan was always to transition the NCHQA from state government to a non-profit. The state still plays a large role within the coalition, but in this arrangement, the NCHQA is better able to withstand political shifts in government and focus on its objectives.
- **Nurture personal relationships among the board members and players to build trust and success.** The NCHQA has been so effective because it is comprised of so many entities that when, combined, influence North Carolina's healthcare system. Members of the board point to North Carolina's collaborative nature, and the long history of partnership focused on quality improvement, even before the NCHQA developed. As demonstrated in North Carolina, it is particularly important that these relationships exist among the highest levels of leadership of the organizations pursuing this work. In order to nurture this sense of teamwork, NCHQA board members point to the importance of personal relationships nurtured through frequent meetings, and add that in-person meetings are critical to foster the sense of camaraderie. These relationships simply will not develop with communication limited to phone calls or e-mails.
- **Identify key opportunities to collaborate.** The NCHQA's representation across all sectors of the North Carolina health system enables it to take full advantage of opportunities to pursue work related to primary care transformation. North Carolina Healthcare Quality Alliance members are able to strategically assign leadership and supporting roles to various partners to maximize external funding opportunities. This process ensures that North Carolina aligns initiatives and avoids duplication of efforts. Essentially, the NCHQA assists in making sure that partners are on the same page.
- **Foster public/private sector collaboration to ensure that initiatives are statewide and reach a large portion of the population.** The fact that the NCHQA is made up of partners from all aspects of North Carolina's healthcare system—including state government, providers, private insurers and others—has ensured that the work it takes on will effect meaningful change within the state. Furthermore, NCHQA members point out that approximately 60 percent of North Carolinians are covered either by North Carolina Medicaid or Blue Cross Blue Shield of North Carolina. In having both of these payers part of the coalition, as well as having CCNC networks and NC AHEC practice support systems, initiatives undertaken by the NCHQA are guaranteed to impact the care for a large percentage of North Carolina's population.

CONCLUSION

The North Carolina Healthcare Quality Alliance demonstrates the effectiveness of public/private collaboration in coordinating health care quality improvement initiatives and setting a statewide common vision for critical stakeholders in the system. The NCHQA's unique blend of private providers, payers, employers, and state agencies enables it

to undertake large-scale broad-based quality initiatives. This level of collaboration also strengthens relationships between the various players in the health system and ensures that initiatives stay focused on improving the delivery of care to patients. Overall NCHQA offers a useful example for states seeking a method to drive statewide quality improvement initiatives across the health care system.

ENDNOTES

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