

The Aligning Forces for Quality Initiative: Background and Evolution From 2005 to 2012

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Introduction

There is considerable interest in using multi-stakeholder alliances and regional coalitions to coordinate quality improvement (QI) efforts across providers and organizations.^{1,2} Proponents of this approach hypothesize that the coordinated efforts of health plans, purchasers, providers, and consumers will yield better and more sustainable outcomes than activities undertaken independently.³ The Robert Wood Johnson Foundation's (RWJF's) Aligning Forces for Quality (AF4Q) initiative is the largest privately funded community-based QI initiative to date, with an expected investment of more than \$300 million over the life of the project.⁴ "The premise of Aligning Forces is that no single person, group or profession can improve health and healthcare throughout a community without the support of others. Aligning Forces for Quality seeks to drive QI by aligning key players in local communities."⁵

In 2006, the RWJF began providing grants and technical assistance (TA) to 4 alliances (multi-stakeholder partnerships in each AF4Q community), launching a program that expanded over time and now includes 16 communities across the country. Funding for the alliances is expected to continue through 2015. The AF4Q alliances are not-for-profit community organizations, either preexisting or established specifically for the AF4Q grant, with representatives from the payer, provider, and consumer sectors. While the RWJF plays an active role in strategy development and program oversight, they have delegated the day-to-day program implementation to a National Program Office (NPO). The authors of this article are a team of investigators from Penn State University, the University of Michigan, the University of Minnesota, and Northwestern University contracted by the RWJF to conduct an independent program evaluation.

The AF4Q initiative is a complex and dynamic program, addressing multiple leverage points in the healthcare system. The overarching goal for the program is summarized by the RWJF as follows: "The [AF4Q] program works to improve healthcare by engaging patients in their care, publicly reporting the performance of physicians and hospitals, and improving the quality of care delivered in each community. The Foundation hopes to provide models that will help propel national reform by providing resources, expertise, and training to help providers, payers and consumers all do their part."⁴

Abstract

Objectives: The Robert Wood Johnson Foundation's (RWJF's) Aligning Forces for Quality (AF4Q) initiative is the largest privately funded community-based quality improvement initiative to date, providing funds and technical assistance (TA) to 16 multi-stakeholder alliances located throughout the United States. The objectives of this article are to describe the AF4Q initiative's underlying theory of change, its evolution over time, and the key activities undertaken by alliances.

Study Design: This is a descriptive overview of a major multi-site, community-based quality improvement initiative.

Methods: A qualitative approach was used with information obtained from program documents, program meetings, observation of alliance activities, and interviews with RWJF staff, TA providers, and AF4Q alliance stakeholders.

Results: AF4Q is a dynamic initiative, expanding and evolving over time. Participating alliances are addressing 5 main programmatic areas: (1) measurement and public reporting of healthcare quality and efficiency for ambulatory physician practices and hospitals; (2) efforts to engage consumers as partners in their own care (consumer engagement); (3) adoption and spread of effective quality improvement strategies to improve care; (4) ensuring the equitable receipt of healthcare; and (5) integration of alliance activities with payment reform initiatives.

Conclusions: The AF4Q initiative is an ambitious program affecting multiple leverage points in the healthcare system. AF4Q alliances were provided a similar set of expectations and given access to substantial TA. While participating alliances have made progress in addressing the AF4Q programmatic areas, given differences in the alliances' composition, market structure, and history, there is considerable variation in program implementation.

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For author information and disclosures, see end of text.

Rather than being a fully developed program at its inception, the AF4Q initiative has expanded its scope and has made several mid-course adjustments as the program has evolved. In this article, we describe the program's evolution and the range of AF4Q-related activities undertaken by participating alliances. Information for this article was obtained through program document review, meeting participation, observation of alliance activities, and interviews with RWJF staff, TA providers, and alliance stakeholders. Readers interested in additional information about our research design and data sources may refer to the article by Scanlon et al in this supplement.⁶

We begin by describing the theory of change underlying the initiative, depicted graphically in a logic model. Subsequently, we describe the evolution of the program from its inception through 3 distinct phases, covering programmatic expectations for the alliances, as well as the guidance and TA provided to support their efforts. Finally, we summarize key activities undertaken by the alliances in each of the programmatic areas that comprise the AF4Q initiative.

Theory of Change: The AF4Q Logic Model

A key step in program evaluation is to articulate the initiative's theory of change—that is, the underlying assumptions and expectations regarding how program interventions will lead to the expected outcomes, and in what time frame. The **Figure** depicts a logic model, developed by our evaluation team with input from RWJF staff, the NPO, TA providers, and key alliance stakeholders. "A logic model helps to focus an evaluation by making a program's assumptions and expectations explicit, and increases stakeholders' understanding about the program or initiative."⁷

As depicted on the right side of the model, the objective of the AF4Q initiative is improvement in key community and population health outcomes such as health status and quality of care received; these outcomes are broad and ambitious, and are envisioned to take time to realize. More proximate outcomes, such as increased transparency about provider quality and price, and improved care coordination, are depicted as intermediate outcomes. The left-hand side of the **Figure** illustrates how the program is envisioned to achieve these outcomes. Specifically, within the community, the AF4Q initiative starts with a multi-stakeholder community alliance, either new or preexisting. The alliance is responsible for establishing a leadership team and organizational structure to support program activities. Leadership is responsible for formulating the alliance's vision and QI strategy within their community. In order to achieve this vision, the alliance develops and implements interventions,

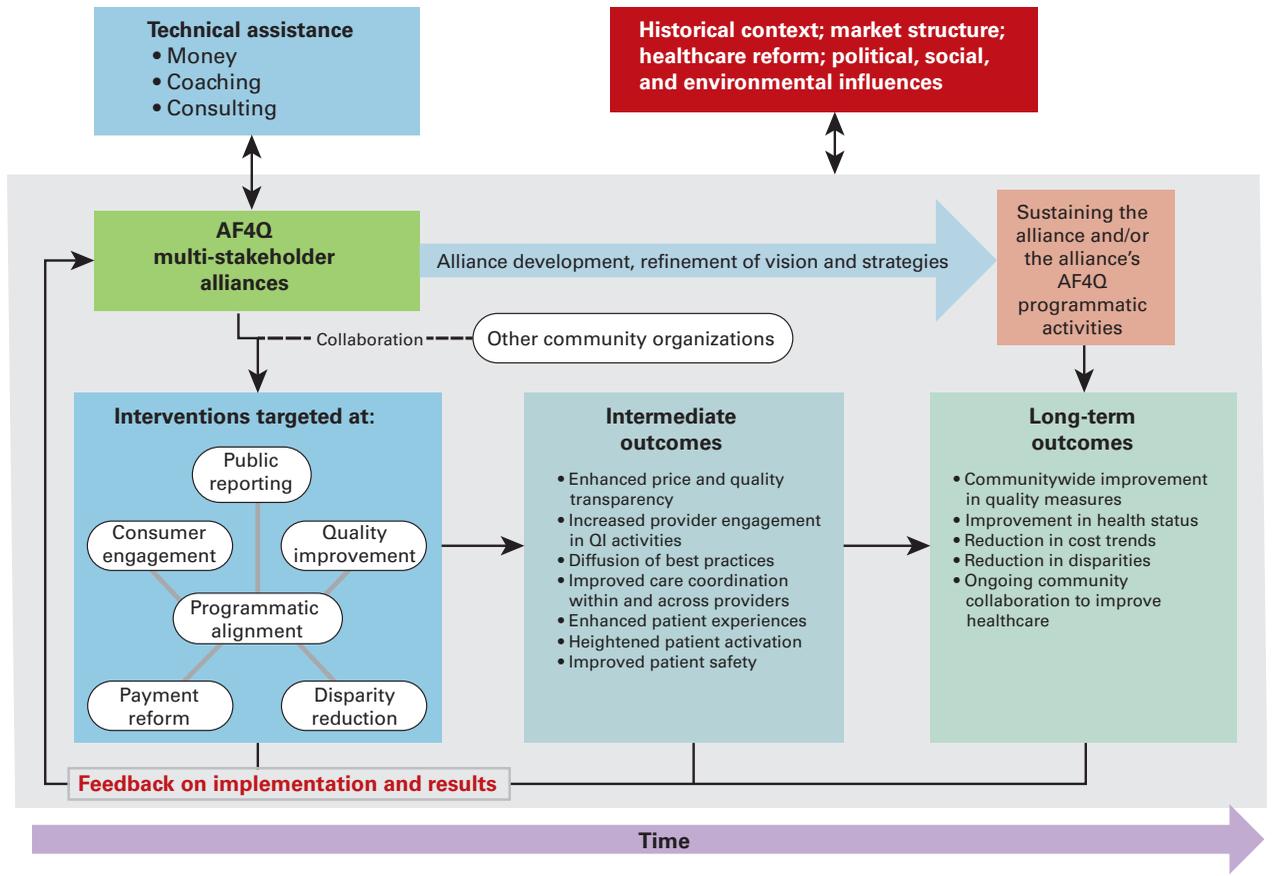
which are activities targeted at facilitating changes in the programmatic areas germane to the AF4Q initiative. They may sponsor these activities directly, or collaborate with other community organizations.

At a minimum, the alliances must address 5 main programmatic areas: (1) measurement and public reporting of healthcare quality and efficiency for ambulatory physician practices and hospitals; (2) efforts to engage consumers as partners in their care (consumer engagement); (3) the adoption and spread of effective QI strategies to improve care; (4) ensuring the equitable receipt of healthcare; and (5) integration of alliance activities with payment reform initiatives. In addition to aligning stakeholders around a common vision, the AF4Q initiative targets alignment of programmatic areas, depicted by connectors in the interventions box.

Across the top of the **Figure**, we indicated that the RWJF provides TA through multiple organizations or individuals with expertise in key programmatic areas to assist the alliances in strategy development and implementation. The model also reflects that the alliances vary significantly in terms of history and market structure and are influenced by factors in the external environment not directly related to the AF4Q initiative. Since the RWJF's objective is to sustain the alliances' activities beyond the anticipated conclusion of the grants in 2015, an important long-term program goal is to build collaborative capacity within the community. This may be accomplished through continuation of the alliance or through alternative models. Finally, as noted on the bottom of the diagram, the alliances' activities and the impact of the AF4Q initiative are expected to evolve over a period of time, with necessary adjustments based on feedback from experiences in program implementation.

While the logic model provides a succinct view of the overall program, it is not sufficiently detailed to guide our evaluation. Accordingly, our team also developed individual models for each programmatic area. This has proved to be a challenging task. For example, the literature does not include a consistent definition of consumer engagement, nor do the existing conceptual models address the array of consumer engagement approaches considered in the AF4Q initiative.⁸ Consequently, we developed a consumer engagement framework targeting 4 categories of behavior: (1) healthy behaviors—the activities individuals perform to maintain health and prevent illness; (2) self-management behaviors—daily activities performed to control or reduce the impact of chronic illness on health status; (3) shopping behaviors—actions targeted at becoming more effective purchasers and consumers of healthcare; and (4) healthcare encounter behaviors—activities undertaken to become more effective

■ **Figure.** The Aligning Forces for Quality Logic Model



AF4Q indicates Aligning Forces for Quality; QI, quality improvement.

self-advocates when interacting with healthcare providers. While not discussed in detail here, our consumer engagement framework illustrates the dynamic nature of behavior change and considers its relationship to individual, group, and community characteristics, including patient activation and the 4 engaged behavior categories. This framework and the other programmatic logic models are available in the online [eAppendix](#) (available at www.ajmc.com). More information about our consumer engagement framework appears in the article by Mittler et al.⁸

Evolution of the AF4Q Initiative

Under the AF4Q initiative, the RWJF provides funding and TA to participants; in turn, the alliances are expected to meet specified goals and objectives. While the program’s initial scope was substantial, it has expanded through enhancements to existing programmatic areas and the addition of new ones. Since the alliances have been charged with a formidable task, the RWJF has made a significant commitment to the provision of TA: it is estimated that TA for each alliance will

exceed several million dollars. In this section, we describe the evolution of the initiative over 3 distinct phases, including the program’s scope, goals, and expectations, and TA offerings.

Phase I

The overarching goal of the initiative’s first phase was to help communities substantially improve the quality of healthcare provided in ambulatory care settings for persons with chronic diseases. Phase I targeted 3 programmatic areas believed to be key drivers of quality (depicted in the interventions box of the logic model): (1) performance measurement and public reporting of performance data; (2) QI in primary care physician practices; and (3) consumer engagement. The RWJF chose to invite 4 communities with a history of stakeholder collaboration on healthcare quality—Detroit, Michigan; Memphis, Tennessee; Minnesota; and Puget Sound, Washington—to serve as the initial communities for the program. Funding began in July 2006 and the Center for Health Improvement (Sacramento, CA) was selected as the NPO. An additional 10 communities

Table 1. Aligning Forces for Quality Grantee Communities

AF4Q Community	Alliance Name ^a	AF4Q Start Date	Website
Albuquerque, New Mexico	Albuquerque Coalition for Healthcare Quality (New Mexico Medical Review Association)	April 2009	www.abqhealthcarequality.org
Boston, Massachusetts	Greater Boston Aligning Forces for Quality (Massachusetts Health Quality Partners)	April 2010	www.mhqp.org
Central Indiana	Central Indiana Alliance for Health (Health Care Excel)	April 2010	www.centralindianaallianceforhealth.org
Cincinnati, Ohio	The Health Collaborative	February 2007	www.the-collaborative.org
Cleveland, Ohio	Better Health Greater Cleveland (MetroHealth)	February 2007	www.betterhealthcleveland.org
Detroit, Michigan	Greater Detroit Area Health Council	July 2006	www.gdahc.org
Humboldt County, California	Aligning Forces Humboldt	February 2007	www.aligningforceshumboldt.org
Kansas City	Kansas City Quality Improvement Consortium	February 2007	www.kcqcic.org
Maine	Maine Aligning Forces for Quality (Quality Counts in close partnership with the Maine Quality Forum and Maine Health Management Coalition)	February 2007	www.mainequalitycounts.org
Memphis, Tennessee	Healthy Memphis Common Table	July 2006	www.healthymemphis.org
Minnesota	Minnesota Aligning Forces for Quality (Minnesota Community Measurement)	July 2006	www.mncommunitymeasurement.org
Willamette Valley (Oregon)	Oregon Health Care Quality Corporation	February 2007	www.q-corp.org
Puget Sound (Washington)	Puget Sound Health Alliance	July 2006	www.pugetsoundhealthalliance.org
South central Pennsylvania	Aligning Forces for Quality South Central PA (Healthy York County Coalition)	February 2007	www.aligning4healthpa.org
West Michigan	Alliance for Health	February 2007	www.afh.org
Western New York	P ² Collaborative of Western New York	February 2007	www.p2wny.org
Wisconsin	Wisconsin Collaborative for Healthcare Quality	February 2007	www.wchq.org

AF4Q indicates Aligning Forces for Quality.
^aIf different from alliance, the AF4Q grantee is listed in parentheses.

(Cincinnati, Ohio; Cleveland, Ohio; Humboldt County, California; Kansas City, Missouri/Kansas; Maine; south central Pennsylvania; West Michigan; Western New York; Willamette Valley, Oregon; and Wisconsin) were added in February 2007 through a competitive grant process. A complete listing of the alliances and their websites is provided in **Table 1**.

Alliances were to publicly report ambulatory care performance information for the community’s primary care providers by the end of 3 years, using local multi-payer data and nationally endorsed quality measures. They were given a broad goal for consumer engagement, which was to transform the physician-patient relationship, in part, by helping patients become better informed and more activated. Alliances were

directed to make “...substantial progress toward engaging community consumers to demand improved ambulatory, chronic illness care quality, including better public information about that care; and motivating those consumers to act on that publicly reported care information.”⁹ Rather than offering a specific model for consumer engagement, the RWJF chose to encourage the alliances to innovate and “Let a thousand flowers bloom.” In addition, the alliances were expected to have substantial and credible consumer representation on their leadership teams. While the RWJF identified QI as a core component of the initiative, no formal requirements were established in this phase. However, alliances were encouraged to engage in activities associated with patient-centered medical homes (PCMHs) and other ambulatory QI programs.

Early TA was built around webinars on topics related to the core programmatic areas, but mainly focused on performance measurement and public reporting. All 14 AF4Q alliances became part of the Consumer Engagement Learning Collaborative (CELC), the primary vehicle through which consumer engagement TA was provided. The CELC provided a structured framework, using a combination of TA consultants and meetings of the alliances, to assist in the development of consumer engagement strategies.¹⁰ The RWJF and the NPO also began sponsoring semiannual national meetings of the AF4Q alliances, providing educational sessions and workshops on programmatic areas, as well as offering opportunities for shared learning among the alliances. Specific progress measures for the alliances were limited during this phase; instead, each alliance developed its own work plans and goals based on general guidance from the RWJF and the Center for Health Improvement.

Phase II

In May 2008, all 14 alliances were funded for the next phase of the program. During this phase, the RWJF more clearly defined its expectations for the alliances in the programmatic areas established in phase I. It also added new programmatic areas: (1) assisting hospitals and other inpatient healthcare facilities with improving quality; (2) focusing and strengthening the role of nurse leaders and frontline nurses in QI initiatives; and (3) using performance measures to capture patient experience of care and reduce gaps in quality for patients of different race, ethnicity, or primary language spoken (REL). During phase II, George Washington University's Center for Health Care Quality became the new NPO. Other changes instituted during this phase included the introduction of systems for measuring and reporting alliance progress on each programmatic area, and reorganization and expansion of the TA program. Three additional communities—Albuquerque, New Mexico; Central Indiana; and Boston, Massachusetts—were added during this phase (see Table 1 for information about these alliances and their website addresses).

During phase II, goals for consumer engagement became more specific, focusing on activities to facilitate consumer use of performance reports for making healthcare decisions and tailoring alliance websites, the primary medium for reporting this information, to be more consumer-friendly. Performance measurement and public reporting requirements were expanded to include reporting of nationally recognized measures of quality, patient experience, efficiency, and prices for hospital inpatients. Alliances also had to demonstrate a plan for achieving the standardized collection of self-reported

data about patients' REL for all healthcare providers, and integrating this information into their measurement, reporting, and QI activities.

To address the new inpatient QI expectations, the NPO and TA providers established 3 QI learning collaboratives open to hospitals in AF4Q communities. The collaboratives included (1) Transforming Care at the Bedside, targeting development of patient-centered care in nursing units; (2) the Equity Quality Improvement Collaborative, focusing on improving the quality of care delivered to cardiac patients, while reducing racial and ethnic disparities; and (3) the Language Quality Improvement Collaborative, which aimed to improve care to non-English-speaking patients. The collaboratives employed a combination of in-person meetings, webinars, and monthly conference calls. Alliances were expected to assist with recruiting hospitals within their communities for participation in the collaboratives. Subsequently, in 2010, the collaboratives were replaced by 3 peer-to-peer hospital quality networks addressing the following topics: reducing readmissions, increasing patient throughput, and improving language services.

Relative to QI in the ambulatory sector, alliances were required to inventory regional QI needs and resources and incorporate this information into plans for sustainable ambulatory QI infrastructures in their communities.¹¹ The NPO also established 2 ambulatory peer-to-peer quality networks in 2010; one was focused on the PCMH, and the other concentrated on implementing a regional learning collaborative. Both the inpatient and ambulatory peer-to-peer networks afforded alliances opportunities to share and learn from each other's experiences and provided access to online resources and tool kits, consultation with QI leaders, and data analysis and feedback.

The NPO introduced new systems for measuring and reporting alliance progress in meeting grant expectations for each programmatic area. Starting with 14 indicators in 2009, the list expanded to 33 indicators, reflecting refinement and expansion of the program. Selected examples of indicators in the area of performance measurement and public reporting are listed in Table 2. TA offerings were greatly expanded and the CELC was disbanded by the NPO. Rather than employing the "one-size-fits-all" approach used in phase I, alliances were given latitude to select from a wide-ranging list of AF4Q-sponsored TA providers covering the main programmatic areas, alliance governance issues, and communication strategies. TA was delivered through a combination of webinars, telephone conference calls, learning collaboratives, workshops, special reports, and direct consulting with TA vendors. Topics addressed in AF4Q programmatic areas

Table 2. Selected AF4Q Performance Indicators for Performance Measurement and Public Reporting

Year	Performance Indicator
2009	Number of alliances that have produced a report of physician performance in the AF4Q regions for review by physicians in those communities
2009	Number of alliances with a plan to stratify performance measures by race, ethnicity, and primary language
2010	Number of alliances that have included a National Quality Forum (NQF)-endorsed measure of ambulatory care patient experience (eg, Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey) in their most recent public report of physician performance
2010	Number of alliances that have incorporated a set of inpatient performance measures, including patient experience, in the most recent public report of performance
2011	By July 2011, alliances had to incorporate NQF-endorsed cost or efficiency measures into their public reports
2011	By June 2013, alliances must have measures on at least 4 outcomes of care for relevant conditions or procedures that pertain to care from at least 50% of the providers in the community. These measures should be available publicly, in an easily accessible, promotion-free website or similar information resource

AF4Q indicates Aligning Forces for Quality.

included making the alliances’ websites more consumer-friendly; physician benchmarking and attribution; capturing and reporting patient experience data; communicating with physicians about performance measurement; standardized collection of self-reported data on patient REL; and the use of consumer decision points in healthcare. Governance topics focused primarily on alliance leadership development and formulating strategies to sustain alliance activities beyond the conclusion of the grant.

Phase III

In 2010, all 17 AF4Q alliances applied for funding for the next phase of the project, which began in May 2011 and continues through April 2013; 16 alliances were selected to continue with the program. The Central Indiana alliance was not selected, because according to the RWJF, the alliance’s stakeholders were unable to agree on a strategy for publicly reporting their performance data, a mandatory AF4Q requirement. New goals for the alliances included (1) setting and achieving explicit, measurable goals around specific clinical conditions (eg, diabetes, acute myocardial infarction) and sites of care (eg, physician practices, emergency departments); (2) focusing efforts on the selected conditions and sites of care to improve quality, cost, and value; (3) experimenting with payment reform; and (4) leveraging federal, state, and local health information technology (HIT) efforts. The new goals reflected the RWJF’s desire to expand the initiative’s focus beyond quality to include cost and efficiency.¹² They also saw the potential of the alliances to capitalize on opportunities stemming from recent legislation, including the Health Information Technology for Economic and Clinical Health Act and the Patient Protection and Affordable Care Act (PPACA).

Alliances were also afforded the opportunity to create direct peer exchanges with fellow grantees. In late 2010, all 8 alliances that applied for the first offering of the peer-to-peer exchange program received funding to visit and learn from other AF4Q alliance leaders. For example, in summer 2011, leaders from the Cleveland alliance visited Maine to learn about the Maine alliance’s success in integrating consumers into their activities.

Finally, AF4Q alliances were also encouraged to take advantage of opportunities associated with healthcare reform legislation. Several alliances applied for and received funding through the Center for Medicare & Medicaid Innovation (CMMI), established through the PPACA. For example, the Cincinnati alliance will participate in the CMMI-sponsored Comprehensive Primary Care initiative. A key objective for this initiative is to establish a system in which Medicare, commercial, and state health insurance plans pay bonuses to primary care doctors who better coordinate patient care.

The Future: Phase IV

The final program phase is projected to run from May 2013 to June 2015. A request for proposals has been issued to the 16 participating alliances, but applications are not due until October 2012. Rather than introducing new programmatic areas, the fourth phase will emphasize development of long-term strategies for sustaining the alliances and/or their activities. Alliances will be charged with developing a “strategic plan for sustainable high value care” for their communities that provides specific goals for improved quality, reduced cost, and a reduction in disparities. We also expect to see realization of some of the long-term outcomes identified in the left side of our logic model.

AF4Q Programmatic Areas

While we have described the program in theory, what has actually occurred as a result of the AF4Q initiative? In the following sections, we briefly describe the range of activities undertaken by the alliances in each of the main programmatic areas. More detailed descriptions of program activities, as well as their short-term impacts, can be found in other papers in this issue.¹³⁻¹⁶ In terms of the logic model, the activities described would appear in the interventions box. Results, impact, and lessons learned are described in the article by Alexander et al in this supplement.¹⁷

Performance Measurement and Public Reporting Activities

From its inception, a central theme of the AF4Q initiative has been transparency through public reporting of healthcare providers' performance.¹⁸ Alliance leaders have noted that performance measurement and reporting has been given more emphasis than other AF4Q programmatic areas, particularly in the early stages of the initiative. According to an alliance leader, "If we look at the dashboard ... the real push is the public reporting piece." Two key objectives for this strategy are to encourage consumers to use performance information in making healthcare decisions, such as selecting a healthcare provider or preparing for a physician visit, and to motivate providers' QI efforts through comparisons of their performance with peers and other benchmarks.

Prior to the AF4Q initiative, 4 of 16 AF4Q communities were reporting physician quality measures and 3 were reporting inpatient quality measures. To date, all 16 AF4Q alliances have released at least 1 report with physician quality measures, with 15 releasing multiple iterations. Fourteen alliances have released at least 1 report on inpatient quality, with most consisting of reformatted performance measures obtained from the Hospital Compare program. Indicators used for reporting physician quality are predominantly based on the Healthcare Effectiveness Data and Information Set (HEDIS) process measures modified for the ambulatory practice setting. The principal medium for reporting performance information has been the alliances' websites (website addresses are listed in Table 1), often incorporating an interactive format that allows individuals to search for information by clinic or provider name, location, or other parameters, such as specialty care or system affiliation. Over time, alliances have expanded both the number of conditions and the number of measures in their reports. They have also begun to include measures of patient experience in their reports, with 8 alliances reporting on patient experience in physician office practices.

Data for performance reports have been obtained from aggregated insurance claims across multiple payers and purchasers and directly from providers. While the alliances have relied extensively on claims data, the lack of clinical data (eg, laboratory results) has constrained reporting primarily to process measures. Consequently, many alliances have targeted electronic health record (EHR) information as a better data source. However, limited penetration of EHRs in many of the AF4Q communities has imposed limits on this approach. Some alliances have employed parallel strategies, reporting process measures from claims data for all physicians and reporting outcome measures for physicians with EHRs. Recently, alliances have been working to incorporate cost/efficiency results into their public reports, such as appropriate use of back pain imaging and generic prescribing rates. Exactly how to measure cost and efficiency by episode, time, clinical condition, and other factors is an area that lacks broad agreement nationally.¹² On the inpatient side, 9 alliances are currently reporting measures related to hospital readmissions. All alliances have inventoried their communities' current approaches to REL data collection. Using this information, alliances are addressing the program's REL collection and reporting component in different ways. Some alliances are working on the standardized collection of REL data (at the ambulatory or hospital level) whereas others, as a first step, are planning to stratify results based on categories of insurance, using Medicaid as a proxy measure of REL.

Consumer Engagement Activities

Initially, AF4Q alliances were given a broad aim for consumer engagement: to transform the physician-patient relationship, in part, by helping patients become better informed and more activated. While the alliances were encouraged to innovate, they often struggled with their consumer engagement strategies, given limited empirical evidence and varying alliance member views of consumer engagement's potential to improve healthcare and health.^{8,10} As a result, the emphasis and scope of activities for each alliance's consumer engagement program varied. For example, the alliance in Memphis dedicated a substantial portion of its resources and effort to improving the whole community's participation in health behaviors, such as regular exercise, healthy eating, and smoking cessation, through its Take Charge for Better Health campaign. The Humboldt County, California, alliance focused primarily on improving self-management of chronic diseases through a series of peer-led workshops (Our Pathways to Health) based on the Stanford Chronic Disease Self-Management Program developed by Lohrig et al.¹⁹ The Wisconsin alliance prioritized healthcare encounter

Reports

behaviors with its Ask Me 3 Campaign that encouraged all consumers to ask their providers 3 essential questions during office visits (ie, What is my main problem?, What do I need to do?, and Why is it important for me to do this?). The Maine alliance focused on getting consumers to access and use publicly reported performance information in making healthcare decisions.

In response to a March 2009 directive from the NPO, the alliances shifted much of their efforts toward improving consumers' awareness and use of information in their healthcare decisions.⁹ Some of the more common activities included efforts to increase the consumer-friendliness of alliances' websites, marketing campaigns to encourage use of the alliances' public reports, and strategies to obtain consumer input into measure selection.¹⁴ Alliances continue to target consumers' self-management and healthcare encounter behaviors as described above, although there has been some restructuring as alliances gain experience with their activities. Alliances' range of activities highlights the tensions between adopting strategies that reach a wider audience using passive activities to cultivate engagement (eg, marketing campaigns, informational pamphlets, websites) versus more costly interventions that actively involve a smaller subset of consumers (eg, small group activities, one-on-one coaching). For example, 9 alliances have activities that focus exclusively on consumers with diabetes. Several alliances designed or adapted interventions specifically targeted at consumers with low literacy levels (10 alliances), parents and/or their children (4 alliances), and senior citizens (4 alliances). Another challenge faced by the alliances when selecting consumer engagement activities is the limited empirical evidence of the activities' relative effectiveness.¹⁷ Finally, in response to the above-cited 2009 NPO memo, which also directed alliances to have meaningful consumer representation in their leadership structure, the alliances have stepped up their efforts to recruit and educate consumers to serve in this capacity. In response, many alliances have established variations of "consumer advisory teams" to provide opportunities for education and consumer input. For example, members of the south central Pennsylvania alliance's Consumer Advisory Council are translating healthcare cost and quality (value) to lay consumers. In Kansas City, the alliance's Consumer Advisory Board members attended a payment reform summit and will be included in follow-up activities.

Quality Improvement Activities

In addition to participating in the previously described AF4Q collaboratives, alliances have engaged in a number of additional QI activities, often in partnership with other

local organizations. Many of these undertakings are limited in scope, consisting of small pilot projects. We have classified alliance QI activities into 6 categories: QI assessments, collaboratives, training programs and QI tool kits, HIT, PCMHs, and practice coaching. At least 4 alliances have undertaken a community QI assessment, inventorying local QI initiatives and identifying provider needs and available resources. Information obtained from the assessments was used to formulate the alliances' QI strategies. The most common form of QI interventions within AF4Q alliances is collaboratives designed to promote shared learning and diffusion of best practices. To date, all alliances are participating in some form of collaborative effort. Some, such as the Cleveland alliance, have initiated their own collaboratives, while others are participating in the previously described AF4Q national learning networks.

Many alliances recognized that providers often lacked basic QI knowledge or experience in instituting QI programs. To address this challenge, some alliances offered training programs and QI tool kits. For example, the Western New York alliance implemented an Improving Quality Improvement program, providing training in QI principles and techniques to over 350 individuals in inpatient and outpatient settings. Others, such as the alliance in Puget Sound, have made QI tools and resources available to providers via their websites.

Alliances have also focused on enhancement of HIT, including the diffusion and meaningful use of EHRs, and promoting the sharing of health information electronically across providers. Conceptually, enhanced HIT has many synergies with the main AF4Q initiative emphasis areas, including performance measurement and public reporting, quality improvement, and payment reform, in particular. Some alliances are leading the HIT work, while others have chosen to partner with organizations, such as regional health information organizations. The HIT activities dovetail with government initiatives, and many alliances have taken advantage of numerous state and federal grants and programs. Most notably, 14 alliances are directly involved with their local regional extension centers and 3 alliances were partners in successfully securing Beacon program funding from the Office of the National Coordinator for Health Information Technology.

Alliances are also participating in the growing PCMH movement on a variety of levels, from involvement in large-scale demonstrations to serving on steering committees for PCMH initiatives led by the state or insurance companies. The alliance in Maine is sponsoring a PCMH pilot program that seeks to implement and evaluate the PCMH model in 26 pilot practices, with the goal of achieving statewide

PCMH implementation. The final category of QI activities undertaken by the alliances is practice coaching. Practice coaches are individuals trained in QI methods who provide onsite QI training and consulting in physician office practices. One of the more noteworthy examples of this strategy is the Practice Enhancement Associates program, which is sponsored jointly by the Western New York alliance and the State University of New York at Buffalo. The alliances' QI activities are described in detail in the article by McHugh et al in this supplement.²⁰

Disparity Reduction/Equity Activities

Working under the assumption that improvement efforts should be data driven, much of the initial AF4Q effort in disparities reduction has focused on capturing data on patients' REL status in order to stratify performance measures by these demographic variables. This enables alliances to identify the magnitude of disparities in their communities, and in the long term, provide feedback on the success or failure of subsequent disparity reduction activities. Accordingly, the NPO and TA providers have devoted most of their efforts in this programmatic area to training alliances to engage providers and health plans in the collection of REL data. Their philosophy of data collection is to allow patients to self-identify their REL status. Given the substantial number of providers in AF4Q communities, diffusion of standardized collection procedures is a daunting task. Consequently, the NPO is considering developing a computerized module to train frontline staff in obtaining this information from patients.

Presently, 13 alliances have stratified some portion of their hospital or ambulatory care quality measures by REL status. While measurement results have been shared with providers, they have not yet been incorporated into public reports, largely due to gaps in the data and concerns over the quality of the information that has been collected. Going forward, the goal for the alliances is to use these data to identify gaps in performance and to facilitate QI efforts addressing problem areas. To date, alliances have had limited engagement in these efforts.

Payment Reform Activities

Alliances were directed by the RWJF in May 2011 to experiment with payment reform. Most alliances have responded by engaging in local multi-stakeholder "payment summits" to discuss potential approaches to payment reform in their communities. Some alliances have moved beyond this stage and begun specific pilot payment programs. For example, the Puget Sound alliance is co-leading a multipayer PCMH reimbursement pilot program with the Washington

State Health Care Authority in conjunction with 7 health plans and 8 medical groups. The Wisconsin alliance is working with the Wisconsin Medical Society on a bundled payment pilot program for total knee replacement and diabetes care, incorporating the alliance's performance measures.

Alignment

As the name of the initiative suggests, alignment is hypothesized to be a key component of the AF4Q initiative. In designing the program, the RWJF believed that the main program components were interrelated and mutually reinforcing for achieving an improved healthcare system. For example, the RWJF believed that transparency related to ambulatory and inpatient care quality was essential for provider quality improvement at the community level, and for meaningful consumer engagement and payment reform. When conceptualizing the AF4Q initiative, the RWJF considered other important levers for achieving improvements in quality, such as providers' adoption of HIT and expansion in insurance coverage. However, the RWJF decided to focus on the levers that their resources could influence most, leaving other important levers to be addressed via public policy changes or the market. Ironically, several of these other levers have changed as a result of the passage of the PPACA (approximately 3 years after the AF4Q initiative launched).

Alignment in the AF4Q initiative can be examined from at least 2 perspectives. The first perspective is from the degree in which different stakeholders align around a common vision for an improved healthcare system in their community. As discussed in the article by Alexander et al in this supplement, we see early evidence that stakeholders share a common vision, even if they are not always certain about the best strategies for achieving their goals.¹⁷ Second, alignment can be viewed as the degree to which the components of the AF4Q initiative (eg, consumer engagement and quality improvement) are co-integrated. Also, as discussed by Alexander et al, our mid-term evidence suggests that this type of alignment has been slower to materialize for a number of reasons, including alliances' experience and expertise, alliances' organizational and governance structures, and the degree of emphasis and TA provided in specific programmatic areas. In many respects, at the beginning of the AF4Q initiative, the main program components were approached in silos. Now, as the AF4Q initiative is at its midpoint, there is greater emphasis on the interdependence of these various areas.

Discussion

The AF4Q initiative is an ambitious community-based QI initiative. Sixteen alliances were given similar funding,

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a common set of expectations, and access to substantial TA. Some of the expectations, most notably consumer engagement requirements in phase I, were intentionally open-ended, allowing broad latitude in interpretation by the alliances. Others, such as the ambulatory care public reporting requirements, are more clearly defined, but still allow a certain degree of flexibility in their implementation. The initiative is a dynamic one, evolving in response to emerging trends in the healthcare field and lessons learned from the alliances' early implementation efforts. In its 5-plus years of existence, the program has expanded in scope, adding new programmatic areas in each successive phase. In many cases, expectations for the alliances have expanded and become more clearly defined, while in other cases, new program requirements or modifications remain somewhat vague. TA has also grown to address the new programmatic areas, and has been customized to meet the varying needs of the alliances.

While the alliances have generally made a concerted effort to respond to the dynamic nature of the initiative, AF4Q leadership has not always been enthusiastic about some of the changes. For example, the added expectation of assisting hospitals with QI efforts in phase II was greeted with mixed feelings by the alliance leaders. Some leaders saw this as a natural extension of the initiative, while others expressed concerns about the added burden and their limited ability to impact hospital QI. As a leader noted, "I don't know how much we can do with hospitals. We don't have capacity to do quality improvement. I think Robert Wood Johnson needs to be realistic about what the alliances will be able to do." Alliances have also taken issue with some of the specific directives, most notably the previously mentioned March 2009 memo clarifying the relationship between consumer engagement and public reporting of performance measures.⁹ Several leaders have expressed skepticism about the feasibility of consumers using public reports to select primary care physicians. This concern is a reflection of limited consumer selection options due to physician shortages and the limits of the measures themselves. Relative to the latter, a stakeholder stated, "I really don't want people picking their family doctor based on a handful of HEDIS measures. What percentage of the physician's practice does that represent?"

While there are similarities in the interventions and activities undertaken by the alliances, there is also substantial variation. In addition to differences of interpretation of the AF4Q initiative's expectations, key influences on this variation are the differences in the alliances' histories, stakeholder composition, and market characteristics. In some cases, the alliances were new organizations formed specifically around the grant.

Others were existing organizations that had to incorporate grant-related activities into their organizational structures and operations. The preexisting alliances varied in their prior experience with the AF4Q initiative's programmatic areas. For example, the Minnesota alliance had a long history of performance measurement and public reporting, and many of the other alliances have looked to this alliance for advice on this topic. Other alliances, such as Maine and Humboldt County, entered the program with substantial experience in QI.

While all alliances have stakeholders representing employers and other purchasers, providers, and consumers, there are significant differences in their relative balances. Developing a common vision and strategy among stakeholders with disparate and often competing interests has been a challenge. Regional differences in market characteristics, such as penetration of EHRs among primary care physicians, has constrained or enhanced opportunities for public reporting of performance measures because clinical information, for example, is not contained in claims data. Some regions are afforded unique opportunities, such as in Western New York, in which the P² collaborative was able to obtain substantial funds from the NY HEAL grant program to augment its AF4Q initiative activities.²¹ Finally, alliances have also differed in the extent to which they collaborate with other organizations or initiatives in their regions to meet AF4Q initiative obligations. For example, in the QI programmatic area, some alliance leaders decided that it would be more productive to associate themselves with existing activities, such as PCMH collaboratives, rather than implement a new program.

If the experience of the initiative to date portends the future, we will likely continue to see differences in the alliances' interventions and their impact on the healthcare delivered in their communities. As previously noted, one of the RWJF's goals for this initiative is to develop models that can be utilized in other communities based on lessons learned. Evaluating such an ambitious program, trying to discern what works, what does not, and why, is a challenging task. Again, we encourage readers interested in understanding our evaluation design to read the article by Scanlon et al in this supplement.⁶ Readers interested in more information about our interim findings are encouraged to read the article by Alexander et al in this supplement.¹⁷ Along with these 2 articles, this supplement includes additional articles detailing the main programmatic areas of the AF4Q initiative and governance of the AF4Q alliances.

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