

# Letter From Donald M. Berwick, MD, MPP, Guest Editor

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Dear Colleague:

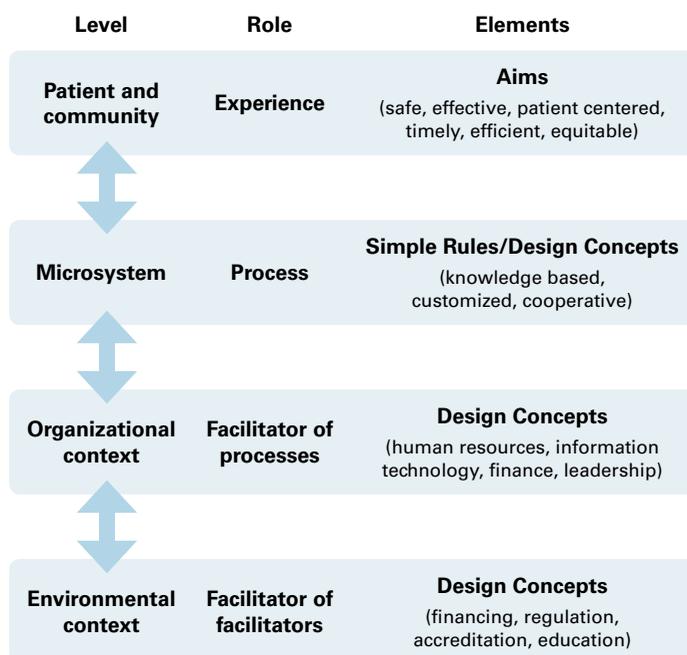
The healthcare philanthropy of the Robert Wood Johnson Foundation (RWJF) has a distinguished history of disrupting conventional thinking. Its Clinical Scholars program added whole new disciplines to healthcare leadership, at first unfamiliar and even unwelcome. Its longstanding investments in highlighting and reducing healthcare disparities, advancing prevention, and encouraging bold quality improvements have prodded the nation's conscience. Following up on the Institute of Medicine's (IOM's) seminal report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,<sup>1</sup> RWJF supported a stunningly ambitious attempt to foster real models of systemic healthcare improvement—a program called “Pursuing Perfection,” which I was privileged to help direct and had an aim nothing short of its title.

The Aligning Forces for Quality (AF4Q) initiative was entirely in that tradition of disruption. From the moment I first heard the notion, I thought that it represented the best of social investment and the wisest of risks. The title clearly pointed a finger at what I had come to believe, and still believe, to be the most important barrier in America—and, frankly, most of the developed world—to the pursuit of truly effective total systems of healthcare: misalignment.

It would not be hard for any thoughtful observer to describe the attributes of an ideal healthcare system. For example, sick or well, we hope for care that is coordinated, seamless, responsive to each individual on his or her own terms, enriched by relevant community resources, continually improving, scientifically reliable, and transparent. We might even suspect (as I do) that care of such high quality would be far less costly than uncoordinated, sluggishly responsive, isolated, self-satisfied care.

Let me say a word more about the idea of “alignment,” and why I think it is so important. Around 2001, in the context of my membership on the IOM committee that wrote *Crossing the Quality Chasm*, I created the diagram shown in the [Figure](#),<sup>2</sup> which I labeled “The Chain of Effect in Improving Healthcare.” I intended it to be a systems diagram, showing 4 layers (or tiers) of systems, which interact and affect each other. They include: (1) a system of “Aims,” comprising the experiences wanted by and for the people served (in effect, the “Triple Aim”); (2) the “microsystems,” or small units of production that attempt to meet those needs (eg, an emergency department, surgery suite, or doctor's office); (3) the organizations that house collections of such microsystems; and

■ **Figure.** The Chain of Effect in Improving Healthcare<sup>2</sup>



(4) the environment that sets the context in which those organizations and microsystems operate (eg, payment, regulation, professional education, and licensure).

Conceptually, these 4 tiers, or systems, ought to—need to—be cognizant of, and coordinated with, each other for the purpose of meeting needs. The microsystem helps the patient; the organization helps the microsystem; the environment helps the organization. That, to me, is “alignment,” and it is crucial to notice the direction of “flow” of service and support. The duty of the environment is to meet the needs of the organization, and not the other way around.

Healthcare today has this wrong, in 2 ways. First, for the most part, those 4 nested systems tick away as if they are independent of each other, accountable only to themselves, perfecting themselves and not their interdependency. For example, policy makers often do not seem to understand the actual circumstances of clinical encounters, and physicians often seem naïve about organizations. Further, when these systems are not cognizant of each other, the “flow” of influence is backward from the viewpoint of improvement: organizations spend their time complying with the environment, and microsystems spend their time complying with their parent organizations. The patient—the need—gets less attention; indeed, patients are sometimes left out entirely. The result is “misalignment,” in which energies get squandered in managing upward, or in separate islands of effort.

When I encountered the AF4Q initiative, I thought this would be a chance to get those 4 tiers aligned, working synergistically, and fully in the service of patients, families, and communities. What an exciting and different prospect that was!

That ideal system of care and supports to care—no matter how clearly envisioned—remains out of reach. It simply does not exist yet, surely not on a large scale. The AF4Q initiative sought to change that by supporting alliances in 16 American communities, calling them to purpose, suggesting frameworks for action, connecting them in a learning collaborative, and providing them generous core funding for nearly a decade. RWJF was not agnostic in its views of what those communities should do; it was highly prescriptive. It expected the communities to act on 5 elements of influence—to “align” 5 “forces” toward perfecting their healthcare systems: measurement and public reporting on performance, consumer engagement, quality improvement infrastructure and capability, addressing healthcare disparities, and reforming payment. The framework for evaluation of effect became clearer throughout

the life of the project, and eventually coalesced on the 3 elements of the Triple Aim: better care for individuals, better health for populations, and lower cost.

The articles in this supplement thoroughly document the processes and outcomes on all elements of the forces encouraged by RWJF, and a robust set of Triple Aim metrics of results. The evaluations are quantitative, in nearly breathtaking scale, with 144 metrics as described in the paper by Shi et al,<sup>3</sup> and qualitative, as in the magisterial summary by Scanlon et al<sup>4</sup> (which is the best single paper on “realistic evaluation” of a large-scale social experiment in healthcare that I have ever seen).

The reader will be well rewarded by careful study of each of these papers, and I will not attempt to summarize them here. Suffice it to say, a simple-minded, 2-sentence summary of the overall Triple Aim results of the AF4Q initiative in Dr Scanlon’s words is: “Except for a small proportion of outcomes, there were no major differences in the rate of longitudinal improvement in AF4Q communities, compared with control communities, on quantitative outcomes related to the Triple Aim. Although the majority of the measures improved in both AF4Q and non-AF4Q communities, there were some exceptions to this improving trend, noticeably in the cost of care and population health.”

However, the deeper story and the actual generativity of the “AF4Q decade” are far more nuanced and positive. As a result of RWJF’s courageous investment, we know far more now than ever about the nature, scale, and variation of the barriers that face American collectives that want to produce health for their communities. We understand the fragility of alliances, themselves, and the high psychological and technical thresholds that communities face in trying to achieve transparency; in gaining the attention and understanding of healthcare consumers; in maintaining energy for, and belief in, metrics; and in staying organized to create health equity. Each of the AF4Q alliances followed its own unique trajectory, and social scientists will, for many years, be mining those stories for detailed lessons and ethnographic and political insights.

It is important to note that the AF4Q initiative rolled out during a period of nearly unprecedented tectonic changes in American healthcare policy, technology, and finance. When the AF4Q program began, the Affordable Care Act was hardly a gleam in an eye, “value-based purchasing” was just beginning, there were no accountable care organizations, databases and electronic medical records were far less capable and extensive than by its end, and the Great Recession was just getting started. If results depend on context, as they do in complex systems, it would

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have been a fool's errand to predict where the AF4Q initiative would land after a decade of contextual revolution.

All of that said, I believe that one additional, valuable harvest of this investment may be to call into further question at least some of the nearly canonical economic and sociologic theory that shaped RWJF's hypothesis about which forces to align. As it turned out, for example, consumers seemed far less interested in the transparency and reporting that AF4Q communities struggled mightily to provide. Performance metrics, at least in this era, did not generally emerge as meaningful, galvanizing, or interesting for care providers as the AF4Q charter seemed to hope. Consumer engagement, another force, developed in interesting forms in some communities; however, broadly speaking, providers of care found that goal far more elusive and less intriguing than I would have thought at the start. In sum, the results of the AF4Q initiative invite a fundamental reconsideration of the very nature and magnitude of the forces worth aligning.

The AF4Q initiative has, and will have, a distinguished legacy in both theory and practice, and its lessons

will enrich the entire field of health services research, and the activities of change agents, for years to come. I hope that the descendant regional health improvement collaboratives<sup>5</sup> will continue to take root, thrive, and multiply, to accelerate the shared learning the nation needs.

Meanwhile, continuing its lineage of bold, game-changing investment, RWJF has moved with high energy into the pursuit of "A Culture of Health," which is already beginning to change the entire American conversation about how we wish to invest our time and treasure in pursuit of well-being. I can easily see the underlying connections between the AF4Q initiative and the Culture of Health programs, the former giving insights, ideas, cautionary notes, and hope to the latter. RWJF's journey of honest inquiry and helpful disruption happily continues.

Sincerely,



Donald Berwick

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## REFERENCES

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