

That Was Then, This Is Now

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“When Aligning Forces started, federal policy was a desert. Now it’s a greenhouse.”

For 20 years, in report after report, researchers have been pointing out wide gaps between high quality care and the care that individuals actually receive.¹ After the landmark 1991 Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, shined a bright light on the problem, a second IOM report described the many policy actions that the federal government could take to “lead by example;” however, few were acted on in the initial years.² A coherent national policy response took many years to emerge. If the difference in quality was a chasm, then the federal policy response was more of a desert—with only a few notable oases of innovation and experimentation. In contrast, private sector action on quality increased, spurred on by the actions of accreditors, purchasers, and a thriving improvement community inspired by leaders such as Don Berwick.³ The conditions were ripe to launch an experiment like the Aligning Forces for Quality (AF4Q) initiative, founded on the belief that, as in politics, all healthcare is local. The initiative drew on the best findings from health services research, emerging experience from other community collaborative efforts, and an understanding of how to drive sustainable change. From these roots, the AF4Q initiative launched with the foundational principle that improving quality requires action by multiple stakeholders working toward a single and clear aim, and united by a shared sense of place (ie, their community). The AF4Q initiative launched into this environment in 2006. Looking back, this was truly a bold step!

In the intervening years, the policy and innovation landscape shifted dramatically, and new federal authorities provided vital levers for advancing quality.⁴ These levers can support and accelerate the efforts of AF4Q communities in many ways; however, their greatest impact in a time of continuing cost concerns may be in creating an environment in which the status quo is no longer a feasible alternative. This provides an opportunity for the AF4Q communities and their partners (eg, the National Program Office, other communities, the Robert Wood Johnson Foundation [RWJF]) to pause, consider their strategy, and align their efforts with this new policy landscape. Some ideas for the AF4Q com-

munities to capitalize on the current policy environment are explored here, organized by the AF4Q initiative core strategies, namely multi-stakeholder coalitions, public reporting of quality information, consumer engagement, and quality improvement.

Multi-Stakeholder Community Coalitions

A focus on multi-stakeholder coalitions as a platform for change is not a new concept^{5,6}; however, it has rarely been supported, tested, and refined to the extent that the AF4Q communities have done. This is a singular achievement, creating a set of prototypes for how the different components of the healthcare delivery system in a given community might collaborate for the express purpose of health improvement. This approach has since been embraced by federal initiatives, including the Beacon Communities Program⁷ and the Innovation Challenge grants of the Center for Medicare & Medicaid Innovation. More recently, a call was issued for a national health improvement communities program, to improve the care of patients with multiple chronic conditions associated with high costs.⁸ Thus, the AF4Q initiative helped to shape the framing and implementation of federal investments, and AF4Q communities are now well positioned to compete for these funds.

Multi-stakeholder coalitions, however, face challenges. Coalitions are, by their nature, fragile; even in the best circumstances, they may affect change slowly. Sustaining interest and investment by disparate partners, particularly in more competitive markets, requires demonstrating impact in ways that are tangible and provide a clear return on investment for the various players, particularly the payer and business communities where the dominant concern is cost. Similarly, market relationships are changing as hospitals and physician practices position themselves to respond to new payment models, such as accountable care organizations, and states move ahead in the implementation of healthcare reform. These changes could undermine the trust established by coalitions. Finally, the reality of responding to so many new federal directives and the speed at which they are expected to demonstrate impact (often in less than 3 years) may require

governance and management changes that could fragment the unified vision that coalitions have worked so hard to attain.^{9,10}

Public Reporting of Quality Information

Public reporting to drive accountability and improvement in the healthcare system is now a well-enshrined strategy in the public and private sectors.⁹⁻¹¹ The Affordable Care Act builds on the many existing federal public reporting programs and calls for additional performance reports, a physician-specific public website, core measure sets across populations, release of Medicare claims data, and an expanded scope of reporting to include the quality improvement activities of health plans (not just their actual performance).¹² (For example, Section 3015 calls for public reporting on provider- and condition-specific quality data, a new Physician Compare website [Section 10331], new priorities, and for funding provider-level quality measures to be set by the Agency for Healthcare Research and Quality [Section 3013]. The new Medicaid Quality Measurement Program will develop and select a core set of quality measures for adult healthcare under Medicaid [Section 2701], and Medicare claims data will be released, for the purpose of evaluating provider and supplier performance [Section 10332].) Meanwhile, the number of states with at least some providers needing to publicly report performance grew to 28 in 2011, and the number of websites providing comparative performance information to consumers grew to 116 in 2011¹¹; multi-stakeholder regional collaboratives have assumed a prominent role in producing such reports.⁹

For AF4Q communities, and the program as a whole, a key question is whether this myriad of new reporting requirements and investments can or should replace local efforts. Public reporting of provider performance (whether at the plan, hospital, or physician level) requires a costly data and measurement infrastructure. If this can be funded—at least partly—through new streams, then communities could reinvest their resources, both fiscal and human, in actual improvement, which is always local. On the other hand, a national public reporting system is unlikely to meet the needs of the many diverse communities in this country unless it can be tailored to local priorities and population characteristics. One potential solution is to use public funding to support regional public reports—thus balancing standardization and tailoring.¹⁰ Some AF4Q communities are already statewide collaborations (eg, Maine and Minnesota), and state legislation can sustain these efforts. Perhaps, more of the community-level alliances could partner with other initiatives in their state to work with any existing state reporting requirements, harmonize specifi-

cations, and transfer some of the infrastructure costs to the state for sustained public reporting.

Consumer Engagement

The stated goal of consumer engagement in the AF4Q initiative is “for consumers to access and use health and comparative performance information to make informed healthcare decisions at key points.” Recent reports on the nation’s progress with this strategy are sobering, however, suggesting that these reports on quality have been difficult for consumers to understand and use, and have unfortunately had minimal impact on consumer choices of providers.^{13,14} In parallel, the demand for greater and more meaningful engagement of consumers at all levels of decision making in healthcare and research has grown, and is evident in many new policy initiatives. (For example, health insurance exchanges will be required to engage consumers [Section 1311(d)(4),(i)(3)], and health plans participating in exchanges will be required to develop a quality improvement plan that includes patient-centered education [Section 1311(g)(1)(B)]. Section 3506 establishes a new program to facilitate shared decision making and Section 3021 enables the Center for Medicare & Medicaid Innovation to test payment models that support shared decision making.) This suggests that consumer engagement strategies can and should be integrated throughout the healthcare continuum (and not just at the point of decision making). So, while consumer use of quality information for healthcare decision making is an important dimension, more is required. As Berwick stated nearly 20 years ago, “Nothing about me without me.”¹⁵

Indeed, experience from some AF4Q communities points to the fact that when improvement initiatives actively focus on fully integrating the consumer’s perspective into their work, the result is nothing short of transformative. Provisions in the Affordable Care Act support a broader view of consumer engagement, and recent initiatives such as the Choosing Wisely campaign can be leveraged by AF4Q communities to achieve synergies between the improvement interests of many and the cost control imperatives of others. At the same time, the explosion of social media, technology, and other innovations is creating new and exciting ways for consumers and patients to engage in their care and be active partners in designing and executing improvement initiatives. The AF4Q communities could and should embrace these opportunities.

Quality Improvement

The third arm of the AF4Q initiative is development of a sustainable regional infrastructure for quality improvement, reflecting the growing emphasis on community-level

action for achieving quality.^{5,16,17} Early reports from AF4Q communities are encouraging, but the empirical evidence of the effectiveness of this approach remains weak.^{16,17} Building a shared capacity for quality improvement goes well beyond a sustainable source of financial resources. It also requires an appropriate organizational home for delivering collaborative learning across practices, and training, staffing, consulting services, and information technology to support systematic quality improvement at both the alliance and practice levels.¹⁵ Several policy initiatives are now available to reduce the substantial barriers to achieving this infrastructure, including new incentives to promote the adoption of electronic health records and their meaningful use, incentives for patient-centered medical homes, health plan reporting of quality improvement activities, and physician recertification requirements (that now involve demonstrating participation in quality improvement activities).

Getting to 2015

Support for the AF4Q communities from the RWJF is set to end in 2015, at least in its current form. In the first 5 years of the AF4Q initiative, communities focused on developing the relationships, trust, and infrastructure (for both reporting and improvement) needed to achieve quality gains. Given the plethora of opportunities engendered by national policy, communities face the new challenges of building on their investments, maintaining momentum and focus, coordinating between the growing number of overlapping community-based initiatives, and delivering measurable improvement. These communities are now well positioned to inform the responses of other communities that are just beginning this journey and need to rapidly adapt to this fertile policy environment. Robust evaluation of this bold experiment will allow us to understand not just if a communitywide approach to quality works, but in what context, and for which populations and quality challenges. We need these answers.

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