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Aligning
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A Checkup on Health Care Markets

Study of 14 communities shows why quality improvement efforts must account for local, regional variations

Patricia E. Powers, M.P.P.A.

Michael W. Painter, J.D., M.D.

“Between the health care we have and the care that we could have lies not just a gap, but a chasm... Americans can have a health care system of the quality that they need, want and deserve... [but] the current systems cannot do the job. Trying harder will not work. Changing systems of care will... These changes will occur most rapidly in an environment in which public policy and market forces are aligned....”

Institute of Medicine, *Crossing the Quality Chasm*¹

As part of the design phase of *Aligning Forces for Quality: The Regional Market Project*, the Robert Wood Johnson Foundation (RWJF) and the Center for Health Improvement (CHI) studied aspects of the health care markets in 14 communities.² Based on the themes and recommendations found in the Institute of Medicine’s *Crossing the Quality Chasm*,³ as well as the advice of a group of national experts, this study attempted to measure and compare a set of seven hypothesized major attributes that well-functioning health care markets need in order to drive sustainable quality and value⁴ in the ambulatory care of chronic conditions.⁵ The study team conducted a scan of 14 communities and scored them on these seven attributes of health care market readiness. The attributes are: (1) community leadership, (2) community ability to support provider quality improvement, (3) efforts to measure performance, (4) efforts to report performance measures publicly, (5) attempts to align provider financial incentives with improvement, (6) status of health information technology infrastructure, and (7) activities designed to engage the community’s consumers in health care quality problems.

While the study found vast differences among the communities in the development of the individual attributes, the differences were less dramatic when it came to overall market readiness. This work nonetheless dramatically underscores the need to account for local and regional variations in any national attempt to improve health care quality. This report discusses the development of the tool used to study these communities, the Market Readiness Matrix (Matrix); the major findings of the study; and their implications for health care policy.

RWJF's impetus for this study was a desire to find credible leverage points that might help guide communities as they work to improve the quality of care. It is part of *Aligning Forces for Quality: The Regional Market Project*, a program designed to bring RWJF's substantial investment in and attention to health care quality to bear in local and regional markets where communities are seeking to drive and sustain high-quality care.⁶ RWJF launched *Aligning Forces* in June 2006 under the direction of CHI.

Key Policy Implications

■ *There are multiple opportunities for intervention at the local level.* This study highlights a number of areas that would benefit from targeted intervention. For instance, communities need help improving their performance measurement regarding quality and price, as well as public reporting of those measures. Similarly, almost all communities need help developing practical approaches to engage consumers in health care quality issues.

■ *All health care is local or, at least, regional.* This study underscores the need to account for local and regional variations in any national attempt to improve health care quality. While the local nature of health care is a recurring theme in health care quality policy discussions, this market scan sheds new light on just how different communities are in their health care delivery, leadership and infrastructure. Ultimately, these differences shape and inform the single most critical driver of health care decisions—the individual's experience receiving health care from her doctor. National efforts must find ways to assess and draw on local and regional strengths in order to succeed.

■ *The interplay, relationship and evolution of market attributes deserve additional study.* These seven key market readiness attributes may not necessarily correlate directly with improved health care quality or value. Further, they may not all contribute equally to a given market's success, or there may be additional important attributes that the study did not examine. Understanding about certain attributes will likely evolve and change over time. For example, real-world experience might show that existing performance measures based on process and so-called intermediate outcomes are not sufficient to drive markets toward high-value care. It may become clear that markets require better performance measures. For example, markets may need measures that provide information that is more likely to appeal to patients and consumers, like outcomes of care for a particular medical condition. It also remains to be seen how improving one attribute or another, or a set of attributes, might ultimately lead to better quality of care in a given community. Future studies should determine which market attributes are most important for communities as they pursue optimum outcomes for their patients with chronic conditions.

■ *The public sector has a critical role to play.* The market scans uncovered many examples of government partnering with private efforts to advance quality. Federal support at the local level includes the leadership of federally contracted quality improvement organizations (QIOs), the Agency for Healthcare Research and Quality providing assistance to local Health Information Technology (HIT) efforts, multiple regional demonstration projects by the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services' transparency initiatives.⁷ At the state level, many state employee purchasing programs and a few Medicaid programs are working with private-sector counterparts to adopt value-based buying strategies. As federal, state and local entities continue to invest at the local level, it will be critical for public and private efforts to work in concert to learn more about the important market dynamics that affect quality improvement and to maximize the effectiveness of efforts to help communities develop well-functioning health care markets.

Background

The inconsistency of health care quality in the United States has proven to be an intractable problem. Despite significant investments by the federal government, the Robert Wood Johnson Foundation and others,⁸ the quality of care all too often continues to be mediocre or suboptimal⁹ and health care costs continue to soar.¹⁰ At the same time, the key relationship in health care—the doctor and patient relationship—is buffeted by multiple competing trends that have progressively weakened this critical dyad. Health care providers face ever-increasing and often conflicting demands from plans, purchasers, the government and even consumers, as the historic veil between consumers and cost lifts in many quarters.¹¹ In addition to increasingly direct exposure to costs, consumers face a bewildering array of health care quality and access problems. Furthermore, without good information about quality, price and other aspects of care, along with a supportive environment to act upon that information, improvement is exceedingly difficult. Without these data, neither doctors nor patients can make informed efforts to improve either at the individual doctor and patient “micro” level or at the overall health care sector “macro” level.¹² As a result, overall health care quality continues to suffer in spite of concerted efforts, and sustainable, affordable improvement remains maddeningly elusive.

Fortunately, many entities—both public and private—are working hard to find ways to develop significantly more information about health care performance and price than is currently available and to help providers and consumers get accustomed to using it.¹³ The federal government,¹⁴ as well as governors and legislators on both sides of the aisle in such states as Arizona, Massachusetts, Minnesota and Washington, have committed to advancing quality within their states.¹⁵ In order to succeed, all these efforts must grapple with differences in the way each community or region delivers, monitors and improves health care.

Based on expert advice and Institute of Medicine recommendations, CHI and RWJF staff and advisors hypothesized that a well-functioning health care market could help drive and sustain high-quality, high-value care and that a number of key attributes would be important aspects of such markets. For instance, project advisors concurred that a well-functioning health care market must have good information about care.¹⁶ Therefore, the scans looked for things like community efforts to develop, gather and publicly report important information about the quality, price and other attributes of health care. Staff and advisors further theorized that the community must have strong leadership in order to get the various fiercely competing players to “come to the table” and work collaboratively on some of these underlying market problems, such as a lack of quality information. The scan also assessed health information technology infrastructure in these communities and whether those communities were using technology to automate the flow of information.¹⁷ And because providers in successful markets should have the ability and resources to improve once they realize the *need* to improve, the scan attempted to assess community quality improvement resources.¹⁸ In addition, consumers should be moving from historical relative passivity to a significantly more active, assertive and informed posture.¹⁹

CHI and RWJF staff and advisors used this theoretical construct to develop a set of seven key market attributes. The staff then developed a report card, the Market Readiness Matrix, to score these seven attributes for each of the 14 scanned communities. In accordance with standard quality assessment approaches, this report card assigned letter grades for each attribute, as well as an overall market score.

Methodology

Recognizing that there are a relatively small number of communities that have any kind of quality activities underway, outside of individual organizational efforts, CHI and RWJF staff and the study's advisers created a purposeful sample of 14 communities. Geographic diversity and size of the community were factored into the selection decision. The 14 sites are Boston; Cincinnati; Detroit; Indianapolis; Madison, Wis.; Memphis; Minneapolis/St. Paul; Oklahoma City; Phoenix; Portland, Ore.; the state of Rhode Island; Rochester, N.Y.; Savannah, Ga.; and Seattle.

The market scan consisted of three key activities:

- **Developing the Matrix**, an assessment tool with common criteria to allow for comparisons across markets in a quantifiable, objective manner. In addition to a self-assessed community leadership component, the criteria were based upon existing quality initiatives derived from national bodies (e.g., the Institute of Medicine, Bureau of Primary Health Care Health Disparities Collaboratives) or market trends (e.g., pay-for-performance, creation of community data exchanges). The rationale was to examine and score the prevalence of these evidence-based or promising quality initiatives at the local level. Communities with higher scores are presumably further along in improving quality than communities with lower scores.²⁰
- **Conducting key informant interviews** with 15-20 local stakeholder representatives (e.g., employers, health plans, physician leaders, consumers and others).
- **Coordinating and convening site visits** with local stakeholder representatives.

The Matrix consists of seven scored attributes or indicators. A brief definition of each is provided below:

1. **Community Leadership.** This score was produced by asking key informants in each community to assess their community's leadership. Questions included: On a scale of 1 to 10, how would you rank the leadership from private-sector businesses on quality issues within your community?
2. **Quality Improvement.** This attribute calculated the percentage of the top 12 physician organizations and the percentage of federally qualified health clinics (FQHCs) that are participating in quality improvement collaboratives.²¹
3. **Performance Measurement.** This attribute calculated the number of top health plans (based on enrollment and payer type) and top physician organizations that are accredited and measuring performance using national metrics, such as the Health Plan Employer Data and Information Set (HEDIS) or patient experience.
4. **Public Reporting.** This score was based on whether performance measures, as defined above, are publicly reported and the extent to which physicians in the community are certified under the National Committee for Quality Assurance's (NCQA) Diabetes Physician Recognition Program and Heart/Stroke Physician Recognition Program.
5. **Provider Financial Incentives.** This score was based on the prevalence of incentive initiatives like the Bridges to Excellence program in the community and whether top health plans are individually implementing pay-for-performance programs with their providers.

- 6. Health Information Technology (HIT) Incentives and Infrastructure.** This attribute measured the degree of electronic connectivity among stakeholders, such as through a regional health information organization or other means; the presence of incentives to participate in these efforts; and the extent to which physicians in the community participate in NCQA's Physician Practice Connections recognition program.
- 7. Consumer Engagement.** This attribute was based on the presence of health plan or employer benefit offerings or physician directories that factor quality into consumer choices for selecting a provider.

The Matrix borrows from the Assessment of Chronic Illness Care, a quality improvement measurement tool developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound. There are four basic scoring levels for each market attribute—A, B, C and D—which may be thought of as optimal, good, basic and limited. The study used this simple scoring to present a composite score that various stakeholders would readily understand.²²

Each component was based upon a ranking and a simple division of the numerator over the denominator. For example, if six of 10 federally qualified health clinics participated in a diabetes collaborative, the component received a 0.6, or 60 percent. Translated to a 12-point scale, the score was 7.2—60 percent of 12. This score was then combined with a similarly calculated score for physician organizations that reflected their participation in quality improvement collaboratives. Component scores within a given attribute were rolled up to constitute an overall score, such as quality improvement. CHI and RWJF staff and expert advisers agreed that this method was fairer than using absolute scores. Also, because there is no evidence that any one attribute or component leads to faster or better quality, neither the component nor the attributes were weighted.

The second key activity involved conducting interviews with 15 or more key informants within each community, including broad-based coalition leaders and members, public- and private-sector purchasers, physician organization and clinical leaders, health plan medical directors, public leaders, consumer group representatives, quality improvement organizations, and others. Using a standard guide, interviews lasted 45 minutes to one hour, on average. The purpose of the interviews was to confirm information, fill in any gaps in the research, obtain interviewees' vision for their community and begin to identify potential technical assistance opportunities. Finally, CHI and RWJF staff made two-day site visits in each region to conduct one-on-one and group meetings with key community stakeholders.

While the market scan is intended to provide a general inventory of key multi-stakeholder initiatives, it should not be viewed as a comprehensive catalogue of every quality initiative in a community and does not reflect individual organizations' efforts. Information for the first four pilots is current as of October 2005 and for the next set of 10 as of May 2006.

Limitations

The embryonic state of many of the seven attributes dictated a low approach to scoring. For example, the *presence* of physician incentives was the main criteria for pay-for-performance, not the percentage of physicians' total income that was eligible for incentives or the total amount that was paid. As the seven attributes evolve, the scoring system will as well.

Most data collected for the Matrix are from secondary sources. Where possible, the study used national data sources in order to maintain consistency across communities. Due to the time frame and scope of the project, collaborative quality initiatives among leading health plans and physician organizations were used as indicators for the entire market. There were a few instances where data could not be obtained. In these instances, a community's score may be lower than it otherwise would have been had the information been available. Similarly, a small number of key informants were unwilling or unable to participate. Sometimes key informants felt unqualified to respond to particular questions, such as rating various sectors with respect to community leadership. In these instances, their response was excluded from the numerator and denominator for that component.

Matrix Results

By synthesizing the quantitative and qualitative data obtained through the 14 scans, the study identified regional strengths and opportunities. As seen in Table 1, the vast majority of markets scored a C in the overall Matrix, suggesting that most communities' health care markets do not yet have strong foundations for improving health care quality.

Specifically, 12 of the 14 communities scored a C, or basic, on the Matrix. Boston alone scored a B, with 43.2 points of a possible 84, while Oklahoma City ranked lowest, with a score of D, or 20.1 points. What marks the differences between the "highest" and "lowest" scoring communities? Boston had strong, B-level performance measurement in place and solid B scores in community leadership, public reporting and health information technology. Oklahoma City, by contrast, had strong community leadership, but almost no incentives or infrastructure for health information technology, only minimal consumer engagement, and few physician financial incentives. Unlike Boston, Oklahoma City had minimal multi-stakeholder efforts in which different market interests work together to improve aspects of care. However, even as the lowest overall scorer, Oklahoma City still outranked Boston in its collaborative provider quality improvement efforts, which demonstrates how significantly communities varied in their scores for individual attributes.

Even communities with nearly identical summary scores, like Rhode Island and Cincinnati (with respective scores of 33.0 and 32.9, both C level), achieved those scores through different means. Cincinnati outscored Rhode Island in such attributes as physician financial incentives, health IT incentives, and infrastructure and consumer engagement, while Rhode Island had stronger scores in quality improvement, performance measurement and public reporting. It remains to be seen which of these attributes might have the greatest impact on a community's quality of care. It is possible that two identically scored communities may ultimately have very different quality outcomes, depending on the impact of each attribute. For example, one community may choose to invest its resources in health information technology and incentives, while another chooses to publish report cards and link physician payments to the results of those reports. While the two communities may have identical composite scores on the Matrix, it is unknown which of their respective investments might actually produce higher-quality care.

It is also important to note that although most communities scored a C, some scored a very high C. For example, Minneapolis/St. Paul's C score was just 1.1 points below Boston's B and nearly twice as many points as Memphis' score, which was at the low end of level C. Similarly, Oklahoma City missed level C by a fraction of a point. As stated above, the key point is that globally there is room for all markets to do more to implement promising improvement initiatives.

Table 1 Market Readiness Matrix Communities in Alphabetical Order

ATTRIBUTES	Boston	Cincinnati	Detroit	Indianapolis	Madison	Memphis	Minneapolis
Community Leadership	7.5	7.4	7.9	8.4	7.4	8.9	8.1
Quality Improvement	1.2	2.6	3.6	2.1	3.4	1.8	6.7
Performance Measurement	9.4	7.2	8.2	6.7	8.2	4.3	6.7
Public Reporting	9.1	6.7	6.8	5.2	6.0	4.7	6.7
Physician Financial Incentives	4.0	3.8	1.8	2.0	1.5	1.0	4.5
Health IT Incentives & Infrastructure	8.2	2.4	0.8	3.5	0.9	1.2	0.0
Consumer Engagement	3.8	2.8	3.7	0.4	1.4	0.8	9.4
Total Matrix Score	43.2	32.9	32.8	28.3	28.8	22.7	42.1
	D C B A	D C B A	D C B A	D C B A	D C B A	D C B A	D C B A
ATTRIBUTES	Oklahoma City	Phoenix	Portland	Rhode Island	Rochester	Savannah	Seattle
Community Leadership	7.2	6.6	7.6	7.2	7.1	5.6	7.5
Quality Improvement	2.3	2.5	2.3	4.2	1.7	1.8	2.7
Performance Measurement	5.4	7.0	8.1	7.7	8.6	7.3	6.8
Public Reporting	3.6	4.0	7.1	7.9	4.7	3.8	5.4
Physician Financial Incentives	1.3	0.5	1.0	2.5	2.4	3.0	4.5
Health IT Incentives & Infrastructure	0.0	0.5	1.3	2.0	0.0	0.0	0.5
Consumer Engagement	0.3	2.0	0.8	1.5	0.0	2.6	0.3
Total Matrix Score	20.1	23.1	28.2	33.0	24.5	24.1	27.7
	D C B A	D C B A	D C B A	D C B A	D C B A	D C B A	D C B A

Total Matrix Scores: D = 0-21; C = 22-42; B = 43-63; A = 64-84 Attribute Scores: D = 1 2 3; C = 4 5 6; B = 7 8 9; A = 10 11 12

Key Market Attribute Findings and Implications

Looking at the average individual attribute scores, there is clearly room for improvement in every area. Across the board, communities scored best (level B) in community leadership and performance measurement, followed by public reporting (level C). On all other attributes, communities scored D's.

Overall, average attribute scores are as follows:

- Community Leadership, 7.5 (B)
- Performance Measurement, 7.3 (B)
- Public Reporting, 5.8 (C)
- Quality Improvement, 2.8 (D)
- Physician Financial Incentives, 2.4 (D)
- Consumer Engagement, 2.1 (D)
- Health Information Technology Incentives and Infrastructure, 1.5 (D)

Community Leadership

Each of the communities exhibited a strong commitment to health care quality, and nearly all showed a high degree of organization and resources to support that commitment with a number of different leadership models. As Table 2 depicts, this was the highest-scoring attribute of the seven measured, with an average score of 7.5 (level B).

Multi-stakeholder organizations

Multi-stakeholder groups bring together health care providers, employers, health plans, consumers and other community members to broadly advance care. The Greater Detroit Area Health Council, Puget Sound Health Alliance in Seattle, and Oregon Health Care Quality Corporation in Portland all serve as multi-stakeholder organizations driving quality advancements. Rhode Island's nonprofit Quality Institute also provides multi-stakeholder leadership, marked by strong leadership from the public sector.

Private employers

In Phoenix and Savannah, national and local private employers are leading the way in their communities. For example, in Phoenix many employers are headquartered elsewhere but have sizeable employee populations in the region. National benefits staff members fly into Phoenix for multi-stakeholder meetings focused on creating better physician performance information and are contributing their company data to a local health data warehouse to achieve this objective. Furthermore, they are helping to educate locally based employers about ways to factor quality into their health care purchasing.

Stakeholders focused on specific attributes

Boston, Cincinnati, Indianapolis, Madison, Memphis, Minneapolis/St. Paul and Rochester each have multiple stakeholder organizations focusing on specific aspects of quality, such as quality improvement, performance measurement and health information technology.

Unions

Union leadership with respect to quality was apparent in Detroit, Indianapolis, Minneapolis/St. Paul and Seattle. In Portland, the public sector union for the Public Employees' Benefits Board (PEBB) is an active participant in PEBB's vision to advance quality.

Table 2 Community Leadership

	Level D			Level C			Level B			Level A		
	1	2	3	4	5	6	7	8	9	10	11	12
Boston									7.5			
Cincinnati									7.4			
Detroit									7.9			
Indianapolis									8.4			
Madison									7.4			
Memphis									8.9			
Minneapolis									8.1			
Oklahoma City									7.2			
Phoenix									6.6			
Portland									7.6			
Rhode Island									7.2			
Rochester									7.1			
Savannah						5.6						
Seattle									7.5			

Health plans

State and local health plans with significant market share in several communities provided noteworthy leadership on quality issues. National plans are also taking the lead on publishing physician-level efficiency, quality measurement and reporting, typically in markets where they are not the dominant health plan.

In addition to the leadership provided by these models, all 14 communities showed some leadership from physicians, ranging from very high in Minneapolis/St. Paul, Madison and Rhode Island, to very modest in Memphis and Oklahoma City. Such leadership tends to come primarily from well-established, multispecialty physician organizations, many of which are nationally known.

Across the 14 communities, Savannah scored lowest on leadership, with 5.6, while Memphis scored highest, with 8.9. Markets scored significantly lower on local public sector involvement than on private-sector or state public-sector leadership. Of course, there is an inherent bias with respect to responses related to community leadership across all key informants as interviewees themselves tended to be leaders within the community.

Quality Improvement

Except for a few cases, most markets do not have strong, effective collaborations across institutions dedicated to improving and spreading quality. Table 3 illustrates that with 10 of 14 markets scoring below a 3.0 in quality improvement and having an average of 2.8 (level D), the need for more community wide collaborations to improve quality is clear. Notably, across the markets, FQHCs were more likely to participate in at least one quality improvement collaborative than were top physician organizations. This finding is likely attributable to the Bureau of Primary Health Care collaborative program,²³ in which about 70 percent of FQHCs in these communities participated. This FQHC participation contrasts markedly with that of other groups of physicians. For instance, only 28 percent of top physician organizations participated in at least one collaborative. Of this 28 percent, more than one-third were physician organizations based in Minneapolis/St. Paul. Both FQHC systems and physician organizations were most likely to take part in collaboratives focused on diabetes care, followed by cardiovascular disease.

Minneapolis/St. Paul received the highest score in this area, largely due to the Institute for Clinical Systems Improvement (ICSI), which is devoted to quality improvement. This local organization is unparalleled with respect to the breadth, depth and spread of its efforts among physician organizations.

Seattle's quality improvement collaborative program, which has been managed by the Washington Department of Health, Improving Chronic Illness Care and Qualis, a quality improvement organization (QIO), for more than six years, is also unique, having trained approximately 1,000 physicians statewide. Boston scored the lowest on quality improvement. Key informants in Boston noted that despite its reputation as a "medical mecca" and the fact that it is home to the Institute for Healthcare Improvement (IHI), there is little quality improvement activity *across* organizations. Stakeholders observed that their community's individual organizations are undertaking internal quality improvement, but cross-stakeholder collaboration would be valuable for benchmarking purposes, as well as to share internal techniques that lead to improved care.

Key ingredients to establishing quality improvement capacity within a community may include a visible national program and resources, such as the program sponsored by the Bureau of Primary Health Care, or a community-based program, such as ICSI or the

	Level D 1 2 3	Level C 4 5 6	Level B 7 8 9	Level A 10 11 12
Boston	1.2			
Cincinnati	2.6			
Detroit		3.6		
Indianapolis	2.1			
Madison	3.4			
Memphis	1.8			
Minneapolis			6.7	
Oklahoma City	2.3			
Phoenix	2.5			
Portland	2.3			
Rhode Island		4.2		
Rochester	1.7			
Savannah	1.8			
Seattle	2.7			

Table 4 Performance Measurement

	Level D	Level C	Level B	Level A
	1 2 3	4 5 6	7 8 9	10 11 12
Boston			9.4	
Cincinnati			7.2	
Detroit			8.2	
Indianapolis			6.7	
Madison			8.2	
Memphis		4.3		
Minneapolis			6.7	
Oklahoma City		5.4		
Phoenix			7.0	
Portland			8.1	
Rhode Island			7.7	
Rochester			8.6	
Savannah			7.3	
Seattle			6.8	

Seattle program. The scan also uncovered interesting fledgling programs and points of leverage in markets predominated by small practices. These include a program sponsored by Blue Cross Blue Shield of Michigan that resulted in several small practices teaming up to advance quality and the Oklahoma City Physicians Resource/Research Network, which sends teams of experts to small practices to assist with quality improvement.

Performance Measurement and Public Reporting

While communities scored relatively well on performance measurement—averaging 7.3 or level B—they did a less impressive job making this information public, with the average score for public reporting being 5.8, or level C (see Tables 4 and 5).

All markets except for Oklahoma City, Phoenix, Portland and Savannah produce comparative health *plan* report cards, most of which are based on nationally recognized measures and are publicly available. Three markets—Boston, Madison and Minneapolis/St. Paul—measure and publicly report collective performance measures at the physician organization level.

Both regional and national health plans in many of the markets are unveiling their own physician-level performance metrics. For example Aetna, CIGNA and United Healthcare are measuring efficiency and, in some cases, specialist clinical measures in such markets as Cincinnati, Phoenix and Seattle. Some local plans, including Regency and Premera in Seattle and the Rochester IPA on behalf of Excellus Blue Cross Blue Shield (BCBS), are conducting physician-level measures. While many physician interviewees expressed dislike for individual performance metrics, these national and local efforts—as well as recent CMS initiatives²⁴—significantly contribute to a shifting perception among physicians that public reporting is inevitable.

The scans did not uncover any collective publicly reported FQHC information with respect to quality improvement. Interestingly, though, across the 14 communities, FQHCs were somewhat more likely to be accredited (41 percent) than physician organizations (34 percent).²⁵

Boston received the highest scores for both performance measurement (9.4) and public reporting (9.1). Memphis scored lowest on performance measurement, with a 4.3, and Oklahoma City scored lowest on public reporting, with a 3.6. The scans confirm that for HMOs, performance measurement has become a required business practice. Performance measurement is beginning to be important for PPO health plans and for physician organizations, but not as extensively as for HMOs at the time of the scan. Markets with active private or public purchasers are more likely to demand such information and make it publicly available.

Table 5 Public Reporting

	Level D	Level C	Level B	Level A
	1 2 3	4 5 6	7 8 9	10 11 12
Boston			9.1	
Cincinnati			6.7	
Detroit			6.8	
Indianapolis		5.2		
Madison		6.0		
Memphis		4.7		
Minneapolis			6.7	
Oklahoma City		3.6		
Phoenix		4.0		
Portland			7.1	
Rhode Island			7.9	
Rochester		4.7		
Savannah		3.8		
Seattle		5.4		

Provider Financial Incentives

In many markets, purchasers and payers are interested in factoring quality results into their payments to the delivery system. Several had implemented or were about to implement the national Bridges to Excellence (BTE) program, a multistate coalition of employers, physicians, health care services and industry experts devoted to providing financial rewards based on quality care. A few communities had homegrown, local and state pay-for-performance programs similar to that of BTE. In most, at least one commercial health plan had initiated some form of a provider financial incentive. These initiatives tend to focus on efficiency, HEDIS-like metrics, or measures for specialist care and generic prescription fill rates. Table 6 shows that provider financial incentive scores averaged 2.4, or level D. The highest scoring markets were Minneapolis/St. Paul

The major national health plans are offering tiered networks, primarily to their self-funded private employers. However, the penetration of tiered plans remains limited, and it is unclear how or even whether consumers are actually using physician-level performance information when it is available. The national plans are also rolling out price and quality information in select markets. Aetna, for example, is posting physician prices for the most common procedure codes in Cincinnati. Both local and national health plans, along with self-funded employers, are increasingly denoting high-performing physicians in their directories based upon varying combinations of efficiency, clinical quality and patient experience.

Minneapolis/St. Paul, the highest-scoring market in consumer engagement with a 9.4, leads the country with respect to engaging consumers in quality. This community provides both comparative plan and clinic-level performance data to the public through community wide Web sites, as well as through many plans' provider directories. For more than a decade, a tiered physician network product, which provides quality and cost ratings to consumers, has been offered in Minneapolis/St. Paul.

The notion of a consumer-driven approach to improving the quality of care yielded mixed opinions from many key informants. In general, state and private purchasers and some union representatives supported the notion, believing it to be a linchpin in their own organizations' strategies to address both cost and quality issues. Some physicians, particularly those representing low-income consumers, expressed concerns about low health literacy and consumer suspicions that the emphasis on quality will just be an excuse for passing more costs onto consumers.

This study offers a new view of the work communities are doing to improve health care. This view is important on several fronts. First, the scans attempt to describe the key components of well-functioning health care markets and then assess and compare those attributes across a set of 14 communities. Second, this component view of health care markets gives communities that are willing to collaborate specific areas to target for improvement. Finally, this perspective is critical because a collaborative, regional market approach that emphasizes alignment of health care market forces is very likely the best practical way for communities to achieve sustainable health care quality and value.

Conclusion

Michael W. Painter, J.D., M.D., is a senior program officer at the Robert Wood Johnson Foundation serving on the Quality/Equality Team. He was a 2003-2004 Robert Wood Johnson Health Policy Fellow; has a clinical faculty appointment with the University of Washington, Department of Family Medicine; and is a board-certified family physician.

Patricia E. Powers, M.P.P.A., is the president and CEO of the Center for Health Improvement and is the national program director for *Aligning Forces for Quality: The Regional Market Project*. She served as president and CEO of the Pacific Business Group on Health from 1990-2000.

NOTES

- ¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the Twenty-first Century*. Washington: National Academy Press, 2001.
- ² For purposes of this study, we defined a community from the consumer's perspective—where the majority of the population lives, works and receives care in an ambulatory setting. For most of the 14 communities in the study, this was equivalent to an SMSA (standard metropolitan statistical area). Region is defined as a geographic area that includes a given community but is larger. A region could be a state, part of a state or part of multiple states. A market is the economic unit in which various health care stakeholders (defined as employers and public purchasers, health plans, providers, and consumers) within a community interact.
- ³ See Institute of Medicine. *Crossing the Quality Chasm*: p. 10: "Health care organizations, clinicians, purchasers, and other stakeholders should . . . work together to organize evidence-based care processes consistent with best practices . . . develop the information infrastructure needed to support the provision of care and the ongoing measurement of care processes and patient outcomes, and align incentives inherent in payment and accountability processes with the goal of quality improvement." And p. 79: "This new rule calls for health systems to be accountable to the public; to do their work openly; to make their results known to the public and professionals alike; and to build trust through disclosure, even of the systems' own problems." And p. 183: "In particular, consumers need to have good information on quality, and the ability to use that information as they see fit to meet their needs."
- ⁴ Health care value here means quality of patient outcomes relative to the cost of the care necessary to achieve those outcomes.
- ⁵ While in some cases evidence may not show a direct correlation between a particular program intervention and actual improvements in quality outcomes, this study, nevertheless, relied on many programs with recognized promise as best practices to advance quality.
- ⁶ *Aligning Forces for Quality* began by funding four pilot communities in July 2006 to help those communities substantially improve performance measurement and public reporting of those measures, the communities' quality improvement capacity, and consumer engagement. Those four pilot communities are: Detroit, Memphis, Minneapolis/St. Paul and Seattle. The Foundation selected these first four pilots non-competitively, and then a next set of 10 based on a national competition. The competitively selected 10 communities are: Cincinnati; Cleveland; Humboldt County, Calif.; Kansas City, Mo.; the state of Maine; Western Michigan; Western New York; Willamette Valley, Ore.; the state of Wisconsin; and York, Penn. The Foundation chose the 10 competitively selected *Aligning Forces for Quality* communities based on the recommendations of the *Aligning Forces for Quality* national advisory committee that oversaw that competition. Funding for the 10 competitively selected communities began on February 1, 2007 to help those communities substantially improve performance measurement and public reporting, quality improvement capacity, and consumer engagement. The scanning work that we describe in this report was separate from the selection of *Aligning Forces* communities. This scan, however, did inform the development and design of *Aligning Forces*. We scanned the four pilot communities first. We then scanned an additional 10 communities that we list in this report. These additional 10 scanned communities are not directly related to the competitively selected set of 10 *Aligning Forces* communities—although there is some overlap between these two sets. The scan that we describe in this report did not inform that *Aligning Forces* competition one way or the other.
- ⁷ See Department of Health and Human Services' Value Driven Health Care Web site: www.hhs.gov/transparency.
- ⁸ Other organizations include the National Committee for Quality Assurance (NCQA), The Joint Commission and American Health Quality Association (AHQA).
- ⁹ McGlynn E, Asch S, Adams J, Keesey J, Hicks J, DeCristofaro A and Kerr E. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, 348(26): 2635-45, 2003.
- ¹⁰ U.S. health care spending rose 6.9 percent to almost \$2 trillion in 2005, and health spending accounted for 16 percent of gross domestic product. Catlin, A, Cowan C, Heffler S, Washington, B and the National Health Accounts Team. "National Health Spending in 2005: The Slowdown Continues." *Health Affairs*, 26(1): 142-153, 2007.
- ¹¹ Robinson J, "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs*, 10: w139, 2002. (Published online March 20, 2002: 10.1377/hlthaff.w2.139); Draper D and Claxton G, "Managed Care Redux: Health Plans Shift Responsibilities to Consumers." Issue Brief no. 79. Washington: Center for Studying Health System Change, 2004.
- ¹² See the discussion of complex adaptive systems in Institute of Medicine, *Crossing the Quality Chasm*, Appendix B, p. 309-310: "The intuitive notion of various system 'levels,' such as the microsystem and macrosystem, has to do with the number and strength of interconnections between the elements of the systems. For example, a doctor's office or clinic can be described as a microsystem. It is small and self-contained, with relatively few interconnections. Patients, physicians, nurses and office staff interact to produce diagnoses,

treatments, and information. In contrast, the health care system in a community is a macrosystem. It consists of numerous microsystems (doctor's offices, hospitals, long-term facilities, pharmacies, Internet websites, and so on) that are linked to provide continuity and comprehensiveness of care."

- ¹³ Some examples of efforts to develop quality and price information include: (1) the Centers for Medicare & Medicaid Services (CMS) effort in making Medicare payment information available for procedures performed in ambulatory surgery centers and in inpatient hospital settings (www.cms.hhs.gov/apps/media/press/release.asp?Counter=1948); (2) health insurer Aetna's efforts to provide online access to physician-specific cost, clinical quality and efficiency information in select markets (www.aetna.com/news/2006/pr_20060613.htm); and (3) health insurer Humana Inc's efforts to provide an online tool that estimates how much customers would have to pay for certain procedures at different local hospitals based on their insurance policies (www.humana.com/corporatecomm/newsroom/releases/PR-News-20050106-130620-NR.html). (Accessed September 11, 2006.)
- ¹⁴ For instance, in August 2006 President Bush issued an executive order requiring federal agencies to share information about the cost and quality of health care services and called for the development of regional quality initiatives to help patients make more informed decisions about their care. The order, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," will require the Departments of Health and Human Services, Veterans Affairs, and Defense, as well as the Office of Personnel Management, which administers the federal employee health benefit program, to coordinate efforts and drive use of interoperable health information technology and quality and price reporting. Under the executive order, federal agencies must implement quality measurement systems that are consistent with consensus standards or contribute claims data for quality measurement purposes. They also must share the prices they pay for care with beneficiaries, and may share prices with the general public. The order requires federal agency compliance by January 1, 2007 (www.whitehouse.gov/news/releases/2006/08/20060822-2.html). (Accessed September 11, 2006.)
- ¹⁵ In Minnesota, the governor's efforts include a pay-for-performance initiative for state-purchased health care, announced in July 2006 (www.governor.state.mn.us/mediacenter/pressreleases/PROD007733.html). The governor of Massachusetts signed legislation in April 2006 promoting greater transparency in health care cost and quality through the collection and publication of relevant data (www.mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=cohhspressrelease&prFile=pr_060412_reform_bill.xml). In September 2005, the governor of Arizona issued an executive order to establish a representative committee of stakeholders to plan for the implementation of a statewide electronic health information exchange (gita.state.az.us). The governor of Washington state has made health care quality improvement a top priority (www.governor.wa.gov/priorities/policy/healthcare) and implemented initiatives to improve transparency and health information technology (www.governor.wa.gov/gmap/forums/Governors_Health_Care_Initiatives_GMAP_Report_for_April_20_2006.pdf). (Accessed September 11, 2006.)
- ¹⁶ See Institute of Medicine. *Crossing the Quality Chasm*, p. 72: "The new rule represents a change in this view of the nature of health care information. It treats information as interactive, real-time, and prospective, and holds that *information is key to the patient-clinician relationship*." [emphasis in the original text]
- ¹⁷ See Institute of Medicine. *Crossing the Quality Chasm*, p. 165: "The committee believes IT must play a central role in the redesign of the health care system if a substantial improvement in health care quality is to be achieved in the coming decade."
- ¹⁸ See Institute of Medicine. *Crossing the Quality Chasm*, p. 108: "Because such efforts can be disruptive to current operations and take extended periods of time to accomplish, health care professionals and organizations need extra support and incentive to undertake them . . . Few health care professionals and organizations can undertake such drastic steps to substantially reorganize their care processes without special (and temporary) assistance."
- ¹⁹ See Institute of Medicine. *Crossing the Quality Chasm*, p. 185: "The committee believes that consumers and patients should have a direct role in rewarding quality care. To have this role, consumers should have choices, receive information about their choices, and have the power to act on those choices."
- ²⁰ This is not to say that higher-scoring communities have better quality outcomes; there are no consistent national comparative metrics to do this at the community level.
- ²¹ Because there is no definitive source on physician organizations, health plan key informants and other community-specific resources were used to identify the top 12 that have at least six affiliated nonspecialist physicians. The physician organizations and FQHCs served as indicators of whether collaborative quality improvement programs for four high-cost/high-volume chronic conditions and prevention were taking place in the community. The Institute for Healthcare Improvement and regional coordinators for the Bureau of Primary Health Care Health Disparities Collaboratives generously provided information for these criteria.
- ²² The maximum Matrix score is 84 points. Rather than using this scale, a letter grade seemed more appropriate to present to community leaders and consumers.

- ²³ Bureau of Primary Health Care Health Disparities Collaboratives (<http://bphc.hrsa.gov/quality/Collaboratives.htm>).
- ²⁴ Some of the CMS public reporting initiatives include Physician Voluntary Reporting Program (www.cms.hhs.gov/PVRP/); Physician Focused Quality Initiative (www.cms.hhs.gov/PhysicianFocusedQualityInit/); and Hospital Quality Initiative (www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalOverview200512.pdf).
- ²⁵ Accreditation may be by The Joint Commission, National Committee for Quality Assurance or URAC.
- ²⁶ IHIE has many data-sharing initiatives, most notably a communitywide clinical messaging project where more than 3,000 providers can access patients' clinical results, including laboratory/pathology, radiology and electrocardiogram reports, transcriptions, and emergency department and hospital encounter information, regardless of where the services were provided in the community.
- ²⁷ Bodenheimer T, Wagner E and Grumbach K. "Improving Primary Care for Patients With Chronic Illness." *Journal of the American Medical Association*, 288(14): 1775-9, 2002.
- ²⁸ Hibbard J, Stockard J, Mahoney E and Tusler M. "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers." *Health Services Research*, 39(4) pt. 1: 1005-26, 2004.
- ²⁹ High-deductible health insurance plans offered in conjunction with health savings accounts covered 3.2 million people in January 2006, more than triple the number covered in March 2005. *January 2006 Census Shows 3.2 Million People Covered by HSA Plans*. Washington: America's Health Insurance Plans, 2006.
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Robert Wood Johnson Foundation

P.O. Box 2316
College Road East and Route 1
Princeton, NJ 08543
(888) 631-9989



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