Many Americans are surprised to learn that the “best health care system in the world” often delivers poor quality care. A 2006 study, for instance, found that we receive recommended evidence-based care only about 55 percent of the time. In 1999, the Institute of Medicine (IOM) reported that more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer or AIDS.

Two years later, another IOM report noted that “health care today harms too frequently and routinely fails to deliver its potential benefits.” The report presented an action plan to bridge the “quality chasm” between the existing health care system and one delivering the highest quality. It recommended building a system that provided safe, effective, patient-centered, timely, efficient and equitable health care, in the face of an aging population and the need for better coordination among various providers and settings of care.

This issue brief looks at efforts to bridge the “quality chasm” by promoting collaborative efforts to improve the quality of health care on the community level. It looks at how local coalitions are advancing the use of health information technology (HIT) to improve quality, reporting quality measures and overcoming challenges going forward.

**Fast Facts**

- A national strategy for quality improvement in health care was published in March 2011, as required by the Patient Protection and Affordable Care Act.

- Aligning Forces for Quality (AF4Q) aims to improve the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

- AF4Q touches nearly 37 million people across 15 states, involves more than 31,000 primary care providers and includes one out of eight hospitals in the U.S.

- The Beacon Community Program, overseen by the Office of the National Coordinator for Health IT, funds 17 demonstration communities to develop innovations that improve the quality of health care delivery while slowing the growth of health care spending.

- A Chartered Value Exchange is a multi-stakeholder collaborative involving community purchasers, health plans, providers and consumers. The 24 CVE collaboratives, under the auspices of the Agency for Healthcare Research and Quality, involve more than 600 health care leaders and represent 124 million lives.

**Underlying all these efforts is the idea that no single solution is the “right” way to boost quality.**

Each community is different, and each coalition is approaching quality improvement in ways best suited to local needs.

The Patient Protection and Affordable Care Act of 2010 requires the secretary of the U.S. Department of Health and Human Services (HHS) to establish a national strategy for quality improvement in health care, which Sec. Kathleen Sebelius did in March 2011. The National Quality Strategy, based on principles developed by multiple stakeholders, aims to guide health reform efforts in three broad areas:

- Better care—higher quality, patient-centered, accessible and safe
- Healthy people/healthy communities—improved population health addressing behavioral social and environmental determinants of health
- Affordable care

Though this guidance is aimed at a national audience, many of the priorities outlined in the national...
Developed in 2005 and launched in 2006, Aligning Forces for Quality (AF4Q) is a Robert Wood Johnson Foundation project to improve the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

It predates the other collaborative initiatives featured here and is the model on which they were based. AF4Q currently works with 16 communities across the country with the goal to improve and sustain high-quality, patient-centered, equitable care by 2015. The program touches nearly 37 million people across 15 states, involves more than 31,000 primary care providers and includes 92,000 hospital beds representing one in eight hospitals across the U.S.

The communities vary greatly in population demographics and geography, ranging in size from a single county to a whole state. The four alliances operating statewide are in Maine, Minnesota, Oregon and Wisconsin. The smallest community project is Humboldt County, CA.

The participating stakeholders range from well established organizations, such as the Greater Detroit Area Health Council, formed in 1944, to newer entities such as the Oregon Health Care Quality Corporation, formed in 2001. Through their work in Aligning Forces, they are focusing on several main areas to improve health:

- performance measurement and public reporting;
- consumer engagement;
- quality improvement; and
- payment reform.

All AF4Q communities have developed and have publicly released a report comparing the quality of local providers’ care. In Oregon, for instance, a 2010 report on quality of primary care in the state allows con-
Improving Health Care Quality Through Community Collaboratives

...sumers to view and compare quality scores of individual provider groups and clinics.

When such comparative information is released, providers pay attention, at least in some communities. For example, in Cleveland, the percentage of primary care practices adhering to recommended diabetes care measures increased from 41 percent to 46 percent between 2007 and 2009.

Hospitals are important participants in the quality improvement goal in AF4Q communities and have committed to increasing the quality and efficiency of care in medical-surgical units. An example is Western New York’s Erie County Medical Center. Nursing staff set a goal to reduce pressure ulcers on their medical-surgical unit to zero and met the goal within one month.

AF4Q alliances are contributing to other national health transformation efforts. Eleven are involved in the HIT Regional Extension Centers set up by the Office of the National Coordinator for HIT. This effort is helping to accelerate the adoption of electronic health records in the 11 communities. Three are involved in the Beacon Community Program, also aimed at building and strengthening the health information exchange infrastructure.

The Beacon Community Cooperative Agreement Program provides funding to demonstrate how health information technology might improve quality, efficiency and population health. It is overseen by the Office of the National Coordinator in HHS. It funds 17 demonstration communities around the country to develop innovations that improve the quality of health care delivery while slowing the growth of health care spending.

The program focuses on the use of electronic health records to improve care coordination aiming toward providing better care, improving health and lowering costs. In 2010, grants to these communities—ones with already high rates of health IT adoption—totaled $250 million.

The Beacon Program is active in a diverse set of communities from Spokane to New Orleans, from Providence to Detroit. The program received many more applications than available funding could support. Participation in the program seems to be highly sought after by communities that have identified specific health challenges that can be met through the use of health IT.

One success story is the Beacon Community project in Oklahoma—the MyHealth Access Network. Oklahoma ranked 50th in state health rankings according to The Commonwealth Fund’s 2009 State Score Card. Life expectancy for those in north Tulsa varied from those in south Tulsa by 14 years. Taking note, leaders and stakeholders in the Greater Tulsa community came together to see what they could do about raising the population health of their community.

More than 50 organizations were involved in the creation of the Greater Tulsa Health Access Network (the forerunner to MyHealth), including payers, providers, purchasers, two universities, and community-based organizations that included the Cherokee and Cree Indian nations. The leadership of this effort chose and supported three health objectives—cancer prevention, population health and care coordination—that could be improved using MyHealth interventions.

Another set of community efforts was launched through the Chartered Value Exchanges (CVE) program.

In January 2007 a federal executive order for health care transparency became effective. In response, the Value-Driven Health Care Initiative was launched by HHS. The program is guided by three key principles:

- All health care is “local.”
- Transparency in measuring and reporting accurate and meaningful information on quality and cost is key for quality improvement and fostering consumers’ engagement in their own health and health care.
- Collaboratives involving key stakeholders groups are critical to foster change on the community level.

The program is administered by HHS’s Agency for Healthcare Research and Quality (AHRQ). The initiative plays out on the local level through multi-stakeholder community quality collaboratives referred to as Chartered Value Exchanges (CVEs).

The 24 collaboratives brought together under the CVE initiative, involve more than 600 health care leaders and represent 124 million lives, one-third of the U.S. population. CVE leaders or stakeholders include purchasers, consumer organizations, health plans and providers.

An important benefit to CVE members is the Learning Network. It is a forum—both real and virtual—for sharing evidence-based practices from value exchanges across the country, allowing the application of lessons learned in one community to another.

The network provides peer-to-peer learning experiences as well as access to experts in areas such as: collaborative leadership and sustainability; public at-large engagement; quality and efficiency measurement; public reporting; provider and consumer incentives; coordinated cross-organizational, cross-stakeholder quality improvement; and health information technology/health information exchange.

To facilitate planning and coordination at both the national level and in CVE communities, AHRQ staff members meet with leadership of other community-based quality improvement initiatives, including: Quality Alliance Steering Committee, National Business Coalition on Health, National Quality Forum, Beacon Community Program, Aligning Forces for Quality Program and Network for Regional Healthcare Improvement.

An example of work in progress through CVE is Minnesota Communi-
ty Measurement (MNCM), a regional health improvement collaborative. It also leads the local Aligning Forces effort. Among activities aimed at quality improvement, MNCM collects and publicly reports data on clinical processes and outcomes measures from more than 550 physician offices and 140 hospitals.

MNCM has had success in engaging providers to use the reported measures to improve care. They report that the number of people with diabetes who receive optimal care has tripled since 2004, when reporting began.

Patient education and engagement is a common goal of community health improvement collaboratives. MNCM established the “D5: 5 Goals for Living with Diabetes” to help people with diabetes manage their condition and choose appropriate healthcare providers. Many collaboratives are working on similar efforts.

Community quality collaboratives, particularly those reviewed here, are playing an important role in transforming our health care system, community by community. (For a side-by-side chart comparing the three types of community initiatives described in this issue brief, please go to http://goo.gl/J0fmx.)

They are supported and funded in part by the private sector—the Robert Wood Johnson Foundation in the case of the AF4Q initiative. Federal dollars fuel the Beacon Community Program, and federal administrative support is the central feature of the CVEs.

However, this federal support is time-limited. The Beacon Community Program funding ends in 2012. The support for CVEs was initially to promote their development and now is primarily through the Learning Network. There is no ongoing federal funding for operating the collaboratives.

There is no question that the initiatives described in this issue brief are needed. The seminal reports referenced earlier, and other studies, have shown that the U.S. health care system falls short of excellence, and that health insurance coverage alone does not translate into quality health care for beneficiaries.

Though there is evidence of improvement in some quality measures, there is also evidence of overuse, underuse and misuse of medical treatment modalities which vary with patient demographics and geography.

The payment reform efforts being piloted to pay for value not volume may or may not resolve some of these issues. Broader experimentation involving local laboratories of quality improvement may help inform a direction for health care nationally. It is toward this goal that community collaborative efforts such as AF4Q, the Beacon Community Program and the CVEs continue to strive.

For the sources used in writing this issue brief, email info@allhealth.org or call 202/789-2300.