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Editors' Introduction

Over the past 15 years Americans have become aware that they are not receiving medical care of the highest quality. Concern about quality surfaced in the 1990s with suspicions that managed care companies were skimping on care to increase the bottom line. It resurfaced, in a different way, in the early 2000s with the publication of a widely reported Institute of Medicine study finding that faulty care in hospitals was responsible for between 44,000 and 98,000 avoidable deaths a year¹ and a well-publicized report by Elizabeth McGlynn and her colleagues indicating that more than half of chronically ill patients do not receive appropriate care.²

The movement to improve the quality of health care is a response to these kinds of concerns, and the Robert Wood Johnson Foundation, which has been concerned about quality since the 1970s, has helped to create and establish the movement. The Foundation did not advertise its work to improve quality of care, and until recently it was not a priority area. Perhaps because quality-of-care grantmaking was carried out within the context of chronic care (which *was* a priority), many staff members did not even recognize that the Foundation was doing so much to improve quality. In this chapter, Carolyn Newbergh, a freelance journalist and frequent contributor to the *Anthology* series, chronicles the Foundation's efforts to improve the quality of medical care in the United States.

This chapter can be read in two ways. One of them is through a public health lens: the recognition that the quality of medical care in the United States is not all that it is cracked up to be and the efforts to change that. The other is through a philanthropy lens. Quality is an area, like health services research, tobacco control, and end-of-life care, where the Foundation has spurred the creation of a field. It did so by funding research, strengthening the capacity of researchers, financing demonstration projects, developing standards, supporting professional organizations, and backing champions who have played and continue to play critical leadership roles.

1. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington: National Academies Press, 2000.

2. McGlynn EA, et al. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, 348(26): 2635-2645, 2003.

Rebecca Bryson knew that she was a complicated patient, but still, she thought that the health care system in Whatcom County, Washington, should be able to do better for her than it did. She had congestive heart failure, diabetes, anemia, gastrointestinal bleeding, and various serious complications, was being treated by 14 doctors, and was taking 42 medications. During her hospitalizations, she was repeatedly given the wrong drug because her various specialists weren't kept abreast of the latest changes others had made. At times, she received medications that she was allergic to or that were intended for someone else. When she was out of the hospital, she had the hardest time getting through to tell her doctor about worrisome symptoms—she had to present a compelling enough case to the receptionist for her to pass her consultation request on to the nurse. Then she had to make a convincing case to the nurse—and once more, if lucky, repeat it all to the doctor. Adding insult to injury, each time she was hospitalized she was served meat. She's a vegetarian.

“Being sick is hard work,” she told a rapt audience during a health care conference.

Bryson's complaints fell on receptive ears. Led by a doctor and a nurse with a passion for improving health care quality, a community coalition of health care organizations in Whatcom County took Bryson's struggles and those of many other patients and families to heart and turned them into a plan as part of the Robert Wood Johnson Foundation's *Pursuing Perfection: Raising the Bar for Health Care Performance*[®] grant initiative. Pursuing Perfection was designed to attack just this kind of system malfunction and breakdown.

The Whatcom County team took as its main goal putting patients—particularly those with chronic illnesses—at the center of the community-wide health care system. Patients and family members took seats on committees to redesign health care processes, and their ideas were treated as gems to be mined. They helped develop two big innovations: the “shared care plan” and the “clinical care specialist.” The shared care plan was a plan to manage the care of patients with chronic illnesses; it contained the patient's diagnoses, medications, lab work results, allergies, lifestyle goals, names of providers, and advance directives. Unlike the normal doctor-ordered plan, however, this one was devised in collaboration with and controlled by the patient. Since it was available both online to all providers within the Whatcom community system and on paper, patients could tote their plan with them anywhere.

“It really appeals to people that you can travel someplace like Seattle or Pittsburgh or Bangladesh and have all your medical information available,” said Conrad Grabow, one of many patients who, with his wife, contributed suggestions for improving hospital processes from the patient's perspective.

The clinical care specialist—or “coach/navigator”—ran interference for the patient, breaking down barriers put up by gatekeepers in the physicians' offices. With access to doctors' own inner phone lines and offices, these nurses or social workers would get vital information that patients needed quickly so their condition wouldn't deteriorate or land them in the emergency department. The coach/navigator also educated the patients, helping them to make lifestyle changes and to minimize setbacks at various stages of their illness.

The program reduced both hospitalizations and medication errors—and resulted in an average cost saving of \$3,000 for each of the 69 patients who participated. “What we learned, I think, is transformative,” said Marc Pierson, the physician who oversaw the Whatcom County grant. “We learned that patients and their small social networks giving support are incredibly ready to help with their health. Health care policy in America is completely devoid of the concept of a patient, a real human being who makes choices and has behavior change. They’re viewed as just cost and liability. They’re as invisible as black people were in the thirties, forties, and fifties.”

Quality Moves onto the National Agenda

Americans everywhere are subject to the dangerous vagaries of the health care system: uncoordinated care that leaves patients open to too many mistakes, care that falls short of what science tells us is the best treatment, little recognition that the patient’s active involvement is invaluable to the healing process, and almost no use of the information technology that has transformed the world outside of health care. Too many people have had mammograms misplaced, the wrong limb operated on, or the wrong dosage of a drug given.

At the dawn of the 21st century, however, a nationwide movement to improve health care quality was attracting considerable attention. “In the area of quality, there’s probably been more traction gained than in anywhere else in health care over the last 10 or 15 years,” said Gail Warden, president emeritus of the Henry Ford Health System in Detroit, who has played numerous important roles during what many are beginning to call a revolution. He is also a former Robert Wood Johnson Foundation trustee.

For much of the previous century, it was simply assumed that American health care was the best in the world and that doctors didn’t need anyone meddling in how they approached their practice. Besides, doctors often said medicine was both an art and a science, and quality was not something that could be dictated or defined. In 1910, the Flexner Report directed the profession to base the education of physicians on scientifically proven treatments, and for many decades that seemed to suffice. There were efforts to improve quality—professional standards review organizations, quality assurance committees, and criteria established by the Joint Commission on Accreditation of Hospitals (now the Joint Commission)—but physicians were largely left alone. It was only in the 1990s, with the widespread adoption of managed care and the concern that managed care companies were skimping on care to fatten the bottom line, that the situation began to change.

Although the longtime confidence about American health care persisted, the people at the front lines knew a different story. The doctors and the nurses had what amounted to a closely guarded secret among themselves about the dangers patients faced, especially when it came to hospital care. Although pharmaceutical breakthroughs and technology were leading to longer lives, they were also adding complexity and increasing the ways in which the system could break down. “I think every one of us, every doctor and nurse, we’ve known since training how unsafe health care is,” Marc Pierson said.

One would think such widespread uneasiness would lead to change. Instead, there was a medical culture that simply didn't want to believe it. "Any time a health care professional or patient runs into a bad outcome, one is always predisposed to think it was natural causes, it could not have been avoided, and not that you screwed up," said Arnold Milstein, the medical director of the Pacific Business Group on Health and a cofounder of the Leapfrog Group, a consortium of employers working to improve the quality and reduce the cost of medical care. "That's why this went on so long—there was not a good read on exactly how unreliable the quality of health care was."

Beginning in the 1980s, research—some of it supported by the Robert Wood Johnson Foundation—began documenting the fact that American medical care was not what it should be. Studies by Robert Brook at the RAND Corporation found variations in the way patients were treated depending on where they lived. John Wennberg at Dartmouth Medical School found that patients with the same health conditions received different treatment depending on the region of the country they lived in.¹ In the 1990s, RAND compiled a review of the literature on health care quality that showed substantial underuse, overuse, and misuse of medical services, exposing patients to more harm than good. These research efforts landed with a muffled thud; the public was not paying attention, and the myth of the preeminence of American medical care continued.

In the late 1990s and early 2000s, the disturbing secret about health care quality began to receive national attention with the publication of two landmark reports by the Institute of Medicine (IOM). In 1999, *To Err Is Human: Building a Safer Health System*, put out a chilling statistic: up to 98,000 people die *unnecessarily* each year in American hospitals because of medical errors. These are from incidents of incorrect medication dosages, infections that lead to fatal pneumonias, and—the kind of error that always commands headlines—operations are performed on the wrong person or body part.² *To Err Is Human* is universally described as a "wake-up call." The public learned—in real numbers—that this was not just a matter of isolated anecdotes but that danger lurked for *everyone* admitted to a hospital.

"When you put a number on something, it allows people to see that this is more than the number of people who die from breast cancer and auto accidents each year," said Janet Corrigan, who, as the lead staff member of the IOM Committee on Quality of Health Care in America, drafted much of the report; she now heads the National Quality Forum. "We wanted folks to understand the magnitude of the problem."

Two years later, the IOM's second report on quality and safety, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which the Robert Wood Johnson Foundation partially funded, reported that a huge divide exists between the care that patients should receive and the care that they get.³ Physicians can't keep up with the flood of medical research and are taking up to 17 years to incorporate new information into their practice. Patient care processes are badly designed and uncoordinated, sorely lacking the information technology that could reduce waste and help in tracking patients' needs. Care for chronic illnesses accounts for nearly 70 percent of health care spending, but services in the community are inadequate to help patients manage their conditions. Furthermore, the payment system rewards providers for doing more, including correcting their own mistakes,

rather than for good outcomes. *The Quality Chasm* also introduced to a broad audience the notion that health care needs to take a page from industry and use its engineering improvement methods to aim for top quality, efficiency, and safety.

“The current care systems cannot do the job,” the report said. “Trying harder will not work. Changing systems of care will.” *The Quality Chasm* then laid out six goals that would become akin to a mantra for the quality improvement movement that these two reports helped inspire. Care should be “safe, effective, patient-centered, timely, efficient, and equitable.” Adding to the case for quality was a seminal study by Elizabeth McGlynn and others at RAND Health, funded by the Robert Wood Johnson Foundation, which found that just 55 percent of adults get health care that meets quality standards.⁴

The movement was off and running, powered by many articulate, passionate, and dedicated leaders and fueled by front-line workers, hospitals, and communities fed up with a system that doesn’t serve its customers well enough. It brought with it many new concepts—such as transparency and accountability of performance, Six Sigma industrial improvement principles, total quality improvement, rapid cycle change, and pay for performance.

The reformers were up against enormous odds, with resistance to change probably the biggest impediment. Many providers, policy-makers, and administrators regarded this big push as nothing more than a fad and certainly not a science. Some of the movement’s leaders, especially the charismatic Donald Berwick, were likened to religious zealots. Critics charged that basing care on protocols or evidence-based medicine—treatment derived from scientific evidence of the most effective approach—reduces health care to “cookbook medicine” rather than the art many have long believed it to be.

The IOM reports instigated a seismic push to transform the lumbering giant that is American health care. Quantifying the damage had struck a nerve. The time was right for reform—to imagine new ways of doing things and to try them out. An October 2006 *Newsweek* report discussed “Fixing America’s Hospitals.” The Institute for Healthcare Improvement’s highly publicized 100,000 Lives Campaign enlisted more than 3,000 hospitals to voluntarily reduce common, preventable medical errors and estimated that it saved 122,300 lives over 18 months.

“There has been a concerted effort by a number of national leaders to raise the quality issues,” said RAND’s McGlynn. “I do think a growing number of people both recognize that there’s a problem and believe that we must do something about it and that we can do something. If that’s the essence of a movement, then, yes, that’s what it is.”

Quality at the Robert Wood Johnson Foundation: Moving from Second to First Violin

Some people say that everything the Robert Wood Johnson Foundation has done since day one has been aimed at improving health care quality. Indeed, one of the Foundation’s initial three priorities, announced in 1972, was to improve the quality of health and medical care. Throughout the 1970s and 1980s, the Foundation financed a number of programs that could be considered to be directed at quality improvement, among them programs to improve quality of care offered at teaching hospitals, to develop tools to measure the quality of home health care, to help rural hospitals provide

high-quality care, and to strengthen the quality of hospital nursing. But its efforts in the area were sporadic and largely unfocused.

The tempo picked up and the focus began to sharpen in the late 1980s and into the 1990s when the Foundation began awarding grants to build knowledge around the concept of quality—particularly, how to measure it. During this time, the Foundation supported studies by RAND’s McGlynn on managed care’s impact on mental health services and care for Medicare patients; Wennberg’s *The Dartmouth Atlas of Health Care*; and the Center for Studying Health System Change, which tracked how managed care was performing. The Foundation awarded grants to create the National Committee for Quality Assurance and the National Quality Forum—two organizations with a goal to develop standards that would measure the quality of care provided by health plans and other providers.

The Foundation made important grants that were in fact directed toward improving quality, although they were not specifically denominated as such. These included grants to develop the chronic illness care model at Group Health Cooperative of Puget Sound, to strengthen hospital nursing, and to give terminally ill patients greater control of the care they receive toward the end of their lives.

During this time, staff members struggled to find ways for the Foundation to take on a greater role in quality. “Everything we were doing was quality but then nothing was,” said Michael Rothman, who led the quality group when it was part of the Foundation’s chronic illness care team. “We were working in areas that would improve quality, but we didn’t phrase it that way,” said Anne Weiss, who heads the Foundation’s Quality/Equality Team today. “When this was named—as it did with the *Quality Chasm* report—it was a signal that the problem was mature enough for us to take it on, as opposed to being a byproduct of things we were doing.”

The difficulty, Rothman said, was that no one at the Foundation knew how to address quality. By the late 1990s, however, interest was building in adopting the science of quality improvement that had worked so well in companies such as Toyota and General Electric. These and other companies were using constant measurement and systematic organizational changes to improve their systems. They had remarkable success in eliminating defects, improving efficiency, and creating superior products.

Rothman brought to the Foundation the idea of supporting a project that had sprung up in Pittsburgh—led by Alcoa’s chief (and later Treasury secretary) Paul O’Neill and Karen Wolk Feinstein, the president and chief executive officer of the Jewish Healthcare Foundation—to redesign health care by bringing in manufacturing methods such as Toyota’s. The Foundation jumped on this idea and provided funds for Pittsburgh’s effort in 2000. Over the following two years, the Foundation authorized another ambitious program that set out to transform American health care by using industry methods for achieving “perfection” and one that would test incentives for physicians and hospitals to provide better care to patients with chronic illnesses.

Looking back in 2006, Steven Schroeder, who headed the Foundation from 1990 to 2002, was startled to realize just how much quality work had been done under his leadership, although it had never been labeled as such. He concluded, “As I think back, we really did do a lot of work in quality. It was like a second violin—we weren’t featuring it as a solo work.”

The move from second to first chair of the violin section came when Risa Lavizzo-Mourey became Foundation president and chief executive officer in 2003. “Going forward, I wanted to emphasize quality improvement as something that people, both internally and externally, thought of the Foundation as doing,” she said. For the first time, quality improvement became a strategic goal of the Foundation, which established a team focused exclusively on developing and monitoring programs in the area of quality.

In its work to improve quality, the Foundation has focused on five areas:

- Measuring the quality of care;
- Re-engineering hospitals and health systems;
- Improving the working conditions of hospital nurses;
- Changing the payment system to give incentives for care that meets quality standards;
- Providing patient-centered care.

A sixth area—reducing health disparities—was not initially considered to be part of the Foundation’s “quality” portfolio, although staff members note that one of the goals of the Foundation’s disparities work was to improve the quality of care received by racial and ethnic minorities. This would change later, and the Foundation’s quality and disparities work would be integrated.

Measurement: The Beginning of Transparency and Accountability

A central tenet of the quality movement is that you can’t fix what you can’t measure, and in the early 1990s a push to develop standards against which you could measure the performance of health plans, hospitals, and doctors began to gain force. “You have to have standards that providers and health plans feel they have to live up to,” said the former Robert Wood Johnson Foundation Trustee Gail Warden.

The National Committee for Quality Assurance

Back in 1989 the managed care industry was exploding onto the national health care scene. There were about 600 managed care plans, two-thirds of them not even five years old, with varying levels of quality and ability to assess and improve themselves. Health maintenance organizations had to meet federal qualification requirements related simply to the benefits they had to provide, not to quality or prevention services. Meanwhile, a skeptical public was concerned that the HMOs’ drive to cut costs meant that their care would deteriorate.

In 1988 the Robert Wood Johnson Foundation gave a grant to an industry trade group to examine the feasibility of an accreditation program to certify managed care plans, with the certification based on standards of quality. The study concluded that such an organization could be created and would be useful in identifying the more and less worthy health plans.

In 1990 the trade group went independent as the nonprofit National Committee for Quality Assurance (NCQA), again with financial assistance from the Foundation. The time was right, said Margaret O’Kane, the founding and current president. “The HMOs were trying to figure out who

they were, and were interested in cleaning up because there were some bad actors. This need converged with what was happening with employers, who were doing continuous quality improvement stuff in their businesses, understood the language of quality, and knew they weren't getting what they needed in health care."

NCQA conducted a survey of 21 managed care health plans in 1991, and in 1995 it began issuing a national report card. Meanwhile, a separate group of employers and some health plans were using the Health Plan Employer Data and Information Set (HEDIS), an evidence-based performance measurement tool that NCQA began to incorporate in 1992 and that has become the backbone of the NCQA accreditation program. With the HEDIS data standards, employers and consumers could compare the performance of various plans on such measures as annual mammograms for women once they reach 50, childhood immunizations, measuring blood-sugar levels for diabetics, and giving beta blockers to people after a heart attack. By 1998 some 75 percent of people enrolled in managed care were in plans accredited by NCQA, and for its part, NCQA was able to show that its measuring of health plans had led to improvements in care.

The National Quality Forum

In 1998 recognizing that health care quality problems were not limited to managed care settings, President Clinton's Commission on Consumer Protection and Quality in the Health Care Industry issued a report, *Quality First*, that called for two organizations to be created to measure quality. One would be a private sector group—the National Quality Forum—that would standardize the many quality measures that were proliferating and publicly report them. The second organization would be a government entity to set goals and priorities for what would be measured, and to set the nation's agenda for quality improvement. While the NCQA measurements were to support a certification process for managed care plans, the National Quality Forum "is a much bigger effort," says Gail Warden, who was the founding board chair for the NCQA and then the National Quality Forum. "It reaches out further to all different members—researchers, providers, physicians, hospitals, and the ambulatory care community."

The National Quality Forum began operating in 1999, but the government body was never established, which led to what many critics describe as the Forum's unfulfilled promise in its early years. Set up as a membership organization composed of those with a stake in the measurements, the Forum was underfunded, and the measures it worked on were often determined by whichever group gave it financial support.

"Its organization and funding were such that it could only work on things it could get money for, so it was very opportunistic about what it could go for," said McGlynn, who also served on an early Forum strategy committee. "The membership approach led it to go after lowest-common-denominator measures. The impact was that it has been antagonistic to what I call 'best-in-class' measurement."

This was occurring at a time when many organizations were promoting their own standards. If you wanted to know the standard of care for, say, pain management, different measures might be available from a home health agency, a nursing home, and a hospital unit, not to mention an

anesthesiologist society, a palliative care organization, and other groups. Instead of finding and promoting the one best measure, the National Quality Forum's measures simply added one more column of measures—adding to the cacophony, not reducing it as was intended.

The National Quality Forum's President, Janet Corrigan, agreed that the organization was not doing its intended job. In 2006 the Forum's board began what she called a "strategic repositioning." The Forum would now take on the annual priority-setting role that the government entity was to have had. It would work with all the interests—such as federal agencies, health plans, employers, unions, and consumer groups—to set national quality improvement standards. It would produce one common set of standards for everyone to use, and it would do this by putting out a call for measures in a particular area—such as breast cancer care—evaluating them all, and selecting the best one.

By deciding to develop its own priorities, Corrigan said, the organization hoped to zero in on areas that would make a substantial difference in the health of the largest number of patients. Corrigan also expected the Forum to develop process and outcome measures for how well patients fare with common chronic conditions over time. "I want to know how much better I will be if I manage this condition this way or that, and what is the difference in cost," said Corrigan. "That requires pulling lots of measures together and rolling them up into overall indicators."

In light of the National Quality Forum's reorganization and a \$3 million Robert Wood Johnson Foundation grant in 2005 to further its work, many observers were optimistic that the Forum would achieve its main mission—giving the nation a common set of standards to evaluate health care quality.

Re-Engineering Health Care

The Pittsburgh Regional Health Initiative

Before the IOM reports on medical errors and quality, and before any hospitals started experimenting with industry engineering techniques to improve health care processes, a coalition of community leaders in Pittsburgh determined that the quality of health care in that city was unacceptable. They decided to use lessons that Toyota had implemented to make a product that was of higher quality and manufactured with efficiency methods that eliminated waste and respected workers' know-how. Their decision would be the start of a new way of thinking about how to cure what ails health care.

Leading the effort were Paul O'Neill and Karen Wolk Feinstein. Concerned about medical errors and care that fell way short of the mark, Feinstein sought out O'Neill, who had instituted policies that reduced injuries at Alcoa to almost zero. The company's culture had changed so much that even after O'Neill left, safety continued to improve.

Together they formed the Pittsburgh Regional Health Initiative, a coalition composed of chief executive officers from 30 hospitals (10 more would join later), health insurers, the attorney general (for antitrust issues), leaders of physician and nursing organizations, and business leaders. The two primary goals were to reduce hospital-acquired infections and medical errors that many in the health care industry believed were a given and probably impossible to eliminate.

“We were the first to say that pursuing anything short of perfection is a path to mediocrity,” Feinstein said in an interview. “Aiming for mediocrity was what our current system was all about.” The initiative introduced quality engineering principles that Alcoa had picked up from the Toyota Production System to redesign hospital processes in order to eliminate safety mistakes and become more efficient. Employees received training at Alcoa in this rigorous system, which the coalition called the Perfecting Patient Care System. Front-line hospital employees, working in teams, were empowered to structure their work for “continuous quality improvement.” The quality innovation would emanate from the front-line workers who deliver patient care, and it would occur quickly, not after months of administrative reports and review. The health care teams would constantly assess how they were doing. In this way, the health care system would be redesigned to recognize and sweep out the stumbling blocks that caused mistakes.

Full disclosure of medical mistakes was critical to fixing processes that stood in the way of workers’ giving patients the best care—but it was also a potential land mine if the media were to publicize the information. In a highly unusual move, the initiative reached an agreement with the city’s two large newspapers not to practice “gotcha journalism” if performance reports were leaked to them that disclosed serious medical mistakes. The initiative promised that the bigger story, the transformation of a regional health system to eliminate danger to patients—the only such effort in the nation—would be a much better story. “We told them, ‘If you publish the [performance] data, you will not have the story, because no one will want to participate with the initiative any more.’ That would have undone the initiative,” Feinstein said.

The Robert Wood Johnson Foundation provided \$1 million toward Pittsburgh’s effort from 2000 to 2003, which proved invaluable not just for the financial support but for the credibility it gave to this endeavor. The Foundation’s funding attracted additional financial support from other sources.

The initiative dedicated itself to eradicating hospital-acquired central line–associated bloodstream infections that occur when a catheter spreads infection through the blood—a condition that causes many deaths. The 32 participating hospitals installed a database system for collecting information. Staff members rededicated themselves to making sure they did everything they knew they should do: they washed hands religiously, used gloves, covered themselves up appropriately, swabbed the area where the catheter was inserted, and avoided using several lines when possible. Mostly, the anti-infection campaign was about relentless attention to sanitation details.

The result? The infection rate was brought down an impressive 68 percent in four years. At Allegheny General Hospital, two intensive care units reduced central-line infections from 49 to six. Deaths from central line–associated infections dropped from 19 to one over a year and remained negligible. Writing in the *The Joint Commission Journal on Quality and Patient Safety*, Dr. Rick Shannon of Allegheny General calculated that every central line-associated bloodstream infection averted saved the hospital nearly \$27,000.⁵

The Veterans Health Administration’s Pittsburgh Healthcare System in Pittsburgh mounted a campaign to stamp out antibiotic-resistant staph infection from its surgical units. A team scrubbed the clean equipment room and the supply room, placed gloves where they were easily accessible,

and put signs to wash hands everywhere. “They did everything they could to eliminate pathways for infection,” Feinstein said. “They would chart everything on the walls. Every day, they would measure progress to see if they were getting better or worse, to understand what drives infection transmission.” The result? They lowered the staph infection rate by 85 percent.

The initiative ran into problems, however, with its goal to eliminate medication errors. The hospitals all used a new database to report errors in a reliable, consistent way, but they were frustrated by troubles in working with it. The largest hospital became preoccupied with other pressing computer matters. A plan to return illegible handwritten prescription orders to physicians fell through when doctors balked.

One discouraging lesson was that the commitment of hospital leaders was not sufficient to bring about wide use of the best practices that were developed. A hospital’s top executives may be enthusiastic supporters, but they have to coordinate many competing interests such as physicians, insurers, boards of directors, employees, government and accreditation commission standards, and they need to make, not lose, money. “Quality is just there, floating with other everyday considerations that have to be balanced,” Feinstein said. “They get rewarded for their bottom line. Quality leaders lose money because of the perverse payment system for coverage we have in this country, which actually rewards errors, because then you get paid for doing more.”

Nevertheless, Pittsburgh made an impressive start, and it continued its quality improvement innovations after the Foundation’s funding ended, taking redesign efforts to ambulatory care practices.

Pursuing Perfection and the 100,000 Lives Campaign

The Cincinnati Children’s Hospital Medical Center’s Cystic Fibrosis Center made a highly risky gesture when it invited parents to attend a meeting at which it would share lackluster performance data related to their children’s health. Of the 116 cystic fibrosis centers across the nation, Cincinnati Children’s was just “in the middle of the pack” when it came to its young patients’ lung functioning, and about 40 percent of the children’s weights—a major indicator of how they were doing—were beneath the 10th percentile for their ages. These two factors are indicators of how long children with this disease, whose average lifespan is 33 years, can be expected to live.

Although the parents were disheartened to learn that the care their children were receiving was merely average, they were impressed with the center’s openness and honesty. So when the hospital asked them to help redesign the system to improve care, they signed on and began sharing ideas and concerns. At first, they divided into two groups—the staff would come up with what it believed were the families’ top 10 priorities for change, and the families would do the same for the staff. Instructively, the providers’ list showed that they often didn’t know what the families felt they needed, said Tracey Blackwelder, an active family participant with four children treated at the center. For instance, the providers believed that reducing wait times in the clinic would be a top priority to parents, but they said no, getting all their needs met at the clinic visit was far more important. So, together with the providers, the families developed a questionnaire that is sent to them two weeks before a visit; in it they note their concerns, the questions they need answered, and any specialists

they need to see. Doctors then structure the clinic visits to meet those needs. “Now when families come in, the doctor is prepared to answer their concerns,” Blackwelder said. “This has helped us all to work together as a team.”

The Center took steps to work more rigorously to improve the kids’ lung function and nutritional status: taking respiratory cultures every three months and closely monitoring the kids’ weight and height, so that measures could be taken early to stop downward spirals. “Height and weight was one area that was very important to parents, and we worked on it a long time,” Blackwelder said. “We made sure any kid under the 10th percentile for height and weight was given a kind of red flag—it was a goal that no one would be in the 10th percentile.” The nutritionist would chart monthly results, and all would cheer as kids made it out of the 10th percentile. “To see this work was pretty cool,” Blackwelder said. Parents also pushed for all kids to be given flu shots to prevent secondary respiratory infections, and parents and doctors kept an eye on innovations at other cystic fibrosis centers to learn the fine points of what was working well elsewhere.

This intensive effort brought the intended results. Fewer than 25 percent of the patients are now in the very low weight category. Eighty-five percent of the children have a quarterly respiratory culture; three years ago, just 50 percent had them. Flu shots are given to more than 95 percent of the kids, up from 40 percent before this effort began. Meanwhile, Cincinnati Children’s learned a major lesson: parent involvement and being open about how it was performing—transparency—were vital to what the center was about.

“The parents changed everything for us,” said Uma Kotagal, Cincinnati Children’s senior vice-president for quality and transformation, who headed up the hospital’s efforts under the Robert Wood Johnson Foundation grant Pursuing Perfection: Raising the Bar for Health Care Performance. (The Cystic Fibrosis Center was but one piece of the hospital’s program.) “They are the real experts when it comes to their children.”

Cincinnati Children’s was one of seven locations to take part in the Foundation’s Pursuing Perfection initiative, an eight-year, \$26-million program initially funded in and managed by the Institute for Healthcare Improvement.⁶ This program was a response to the IOM’s two reports, *To Err Is Human* and *Crossing the Quality Chasm*; the Institute of Healthcare Improvement President, Donald Berwick, had a major hand in drafting its executive summary. Pursuing Perfection took the report’s blueprint for redesigning the care processes as its own—insisting on care that was safe, effective, patient-centered, timely, efficient, and equitable. It also drew from the Pittsburgh Regional Health Initiative, a “very helpful prototype,” according to Berwick.

Pursuing Perfection aimed at creating one or more models for ways to transform health care—creating a new “Toyota” model for redesigning health care. It used industry methods to improve patients’ health outcomes by changing the patient care processes. It insisted that hospitals’ troubles were systemic and that blame for them could not be placed at the feet of workers who were burdened by a broken system. To improve outcomes, it sought to change patient care systems. Simply achieving benchmarks for average performance wouldn’t be adequate anymore; Pursuing Perfection hospitals would aim for perfection.

Industry methods included “continuous quality improvement” and “rapid cycles of change.” As with Pittsburgh, front-line employees were empowered to constantly assess their processes, suggest innovations, implement those that were improvements, and monitor how they worked out. The program also borrowed from the Six Sigma approach used at Motorola and General Electric, with its emphasis on rooting out defects. The seven sites applied evidence-based medicine to ensure that all patients benefited from high standards, but they customized care for some whose cases were more complex or unusual and needed different approaches.

All of the hospitals made great strides in improvement, and some came close to transformation, especially Cincinnati Children’s. Here is a sampling:

- Tallahassee Memorial Health Care wanted to find out why its death rates were well above the national average. As a Pursuing Perfection grantee, it examined the hospital’s death records and found a number of contributing factors: not noticing when a patient was deteriorating and needed quick intervention, communication failures such as between providers and nurses or between a patient and a nurse, and deficiencies in the patient’s diagnosis and treatment. The Institute for Healthcare Improvement suggested a number of strategies that Tallahassee adopted. It created, for example, rapid response teams to provide nurses with the resources they needed when they sensed a patient’s condition was quickly worsening, and “multidisciplinary rounds” with a physician, a nurse, a pharmacist, and a therapist to improve patients’ communication and care planning. The upshot? Deaths were reduced by almost 31 percent between 2001 and 2004. This translated to 53 percent fewer deaths from acute myocardial infarction, 62 percent fewer from heart failure, 41 percent fewer from stroke, and 46 percent fewer from pneumonia.
- At McLeod Regional Medical Center in Florence, South Carolina, the medication error rate was at the low end of the national average, but leaders there felt that it could be far better. McLeod set a goal of zero drug mistakes. It created teams to make plans to improve medication safety. More doctors began using handheld computers to track drugs. Medications whose names look and sound alike were separated on carts. Top administrators toured the floors daily, asking staff about impediments to medication safety. The hospital bought a computerized drug-ordering system, which spots a patient’s possible medication interactions and eliminates one fertile spot for errors: the handwritten prescription order. And it instituted a “medication administration checker” that scans bar codes on a patient’s armband and the medication to confirm that this is the proper drug and in the proper amount before it is given. The outcome? The number of adverse drug events declined from more than two for every 1,000 doses in 2002 to less than one per 1,000 in the first half of 2004.
- Hackensack University Medical Center in Hackensack, New Jersey, is known as one of the best hospitals in the country for cardiac care, but it wanted to become even better. Among other things, the hospital speeded up processes and added safeguards to ensure that no necessary care step was forgotten. The emergency department coordinated care with paramedics, who ran EKGs on the patient in the ambulance, sending results ahead. Nurses received more training on how to best tend to patients having heart attacks. For example, if the EKG indicated certain specified warning signs, the catheterization lab and a cardiologist were notified immediately, and an emergency department nurse gave the patient aspirin and beta blockers and rushed him or her to the catheterization lab. The result? Death from acute myocardial infarction was lowered to about 5 percent, well below the 10.9 percent national average.

Although much was learned in Pursuing Perfection, and the sites showed how to accelerate the pace of change, as had been hoped, the biggest goal was not achieved. “The bottom line, of course, is this: We do not have a Toyota in health care,” wrote Berwick, along with the executive director of the Institute for Healthcare Improvement, Andrea Kabcenell, and Thomas Nolan, an Institute senior fellow, in an article for *Modern Healthcare*. “The project’s primary goal—total system transformation with unprecedented total performance—remains, frankly, to no one’s surprise, still out of reach. But it is no longer out of sight. The progress has been extraordinary.”⁷ Berwick himself, although pleased with the overall effort, faulted the program for not working seriously with hospital financial officers on the basic monetary issues that can hinder quality improvement. “We dropped the ball on the financial case,” he said.

Many of the lessons from Pursuing Perfection were used in the Institute for Healthcare Improvement’s learning collaboratives and became resources on the Institute’s Web site. They were also keys to the 100,000 Lives Campaign, a highly publicized effort to prevent medical errors in the more than 3,000 hospitals that adopted evidence-based strategies such as giving beta blockers and aspirin to heart attack victims; using rapid-response teams for medical crises; and checking at each juncture to be sure that the correct medications were being given to patients. The campaign attracted widespread media attention when it announced that it had saved more than 122,000 lives over 18 months.

Although experts raised probing questions about how the campaign arrived at the number of saved lives and the initiative’s assumption that rapid-response teams were a best practice, the campaign was largely viewed as a victory for quality improvement. “This is the most thrilling episode in my whole career,” Berwick said in an interview. “It showed it could be done.” In late 2006, his institute expanded on the momentum from the 100,000 Lives campaign by announcing the 5 Million Lives Campaign, which would work to prevent 5 million injuries from causes such as bedsores, drug-resistant staph infections, and congestive heart failure.

Nursing: Transforming Care at the Bedside

Like nearly all hospitals, says nurse Millicent De Jesus, her general surgical unit at Cedars-Sinai Medical Center in Los Angeles has had its “fair share of medication errors.” The nurses in the unit felt they knew why: they prepared each patient’s medications at the nursing station, where doctors, patients, and family members constantly interrupted and distracted them. So when the nurses’ station was being redesigned and their input was solicited, the nurses came up with the idea of creating a separate medication room where they wouldn’t be disturbed. And they gave a lot of suggestions about what would make the perfect medication room. The idea was turned into a reality, and it’s called the “no-interrupt zone.” “The nurses were very happy because they had a say, they were involved in how they would like our environment changed and processes improved,” De Jesus said.

De Jesus’s 48-bed general surgery unit is one of the success stories to emerge from *Transforming Care at the Bedside*[™], another Foundation-funded initiative that is managed by the Institute for Healthcare Improvement. Begun in 2003 as a pilot with three hospitals that tried out concepts, it expanded in 2004 to 17 medical-surgical units in hospitals around the nation.

Transforming Care at the Bedside was designed to address the nation's pressing nursing shortage and tie it into the Foundation's focus on improving the quality of health care. It targeted what much research has shown to be the underlying reason that people were either not attracted to nursing or leaving it in droves—the poor working environment. Nurses put it this way: they spend too much time on paperwork and hunting down equipment all over the hospital; physicians are rude and disrespectful to them; they have little autonomy; and they're given little support when the workload gets stressful. Finally, they don't have enough time to do the job they were trained for—taking care of patients.

“We wanted to do what we could to change the work environment to make nurses excited about the work they do,” said Susan Hassmiller, the Robert Wood Johnson Foundation's senior program officer who oversees Transforming Care and is herself a nurse. “We believed that if we could get more nurses really engaged and excited about the care that they give, they would stay and give a better quality of care. It's not really brain surgery.”

The Transforming Care at the Bedside units started their work with what is called a *brainstorming deep dive*, with front-line nurses sitting in a room, thinking about the care they provide and the countless processes behind the care, and considering what they could improve in their work environment and patient care. (Later, they would regularly do smaller dives, which they called *snorkels*.) The innovations they came up with out of this brainstorming were always in one of four areas of focus: reliability, getting the waste out of work processes, patient centeredness, and increasing nurse vitality. Worthy ideas were tested quickly and then “adopted, adapted, or abandoned,” in the lingo of the program.

The top priority for the nurses in the units was increasing their time by the patient's side. Nationally, hospital nurses spend an average of about 35 percent of their time with patients; the program set a goal of 70 percent at the bedside. “How does this goal tie into quality?” Hassmiller asked. “If the nurse is not in the room observing a patient's color, activity, smell, and sounds, something bad could happen. You will have a patient falling, having adverse effects, developing bedsores.”

Transforming Care at the Bedside emphasizes a bottom-up approach, with nurses who deliver patient care devising better ways to do things. This requires support of the nurses' ideas by both the hospital's administrators and its middle managers. The bread and butter of the program is identifying small changes that make a big difference. Here are some of the modest proposals nurses have come up with:

- Put look-alike, sound-alike medications on separate carts;
- Create “lift teams” that help nurses if they have a patient who needs to be turned or lifted—thereby preventing injuries that commonly plague nurses;
- Move some supplies such as linens into patients' rooms instead of keeping them in supply cabinets on the floor;
- Assign nurses to specialize in admissions so that other nurses aren't distracted by the need to suddenly admit a new patient;
- Reduce paperwork requirements.

At Los Angeles' Cedars-Sinai, nurses now accompany physicians on rounds. Doctors had always resisted this at Cedars-Sinai because they believed that having a nurse with them would take up too much time, said Peachy Hain, who heads the Cedars-Sinai Transforming Care unit where De Jesus works. "We told the doctors, 'We have to call you 10 times during the day because we can't read your orders and we can't read your mind. If we're there with you on rounds, we won't be bothering you the rest of the day.'" Walking rounds and reviewing each patient's care plan together led to more courtesy, respect, and teamwork among doctors and nurses—and improved the nurses' enthusiasm for the job. "The doctors don't get angry at the nurses anymore because of that camaraderie they developed constantly walking rounds, planning care together, coordinating what needs to be done for the patient," Hain said.

At the Cedars-Sinai unit, the amount of time lost to paperwork has gone down from 30 percent to 7 percent. The nurses designed a "patient care pack" that outlines what patients need to know about their stay. In the patient's progress notes, the nurse is now able to write, "progressing per patient care pack," instead of repeatedly writing the same notes for each patient. They jot down only what is abnormal or a point that wasn't in the care pack. "It helps when you have an environment where nurses feel there's a better future not just for patients but for the staff because they're being listened to and appreciated," Hain said.

The program is currently being evaluated by a team from the University of California, Los Angeles, and RAND Health. According to the leader of the evaluation team, Jack Needleman of UCLA, preliminary data show that voluntary departures by nurses from Transforming Care at the Bedside units have declined and that some units that have had difficulty recruiting in the past are reporting waiting lists for positions. The units are testing, on average, one innovation per month. As a result of this work, nurses on the Transforming Care at the Bedside units are spending more than half their time in direct patient care, with one hospital, Cedars-Sinai, increasing the percentage of time in direct patient care from 47 percent in the first six months of the program to 71 percent in the last six months it reported.

Rewarding Results, or Experiments in Pay for Performance

The nation's irrational payment system rewards health care providers for mistakes. Healthier patients mean fewer occupied beds and less revenue for hospitals. If the wrong kidney is removed from a patient, the surgeon and the hospital make more money out of correcting the tragic mistake than if the correct kidney had been taken out. A physician who decides to manage his diabetic patients more aggressively—more tracking of tests, e-mail and telephone consultations, and ongoing educational assistance about lifestyle adjustments—will likely find that patients have fewer complications and thus fewer office visits and hospitalizations. He or she can lose money by providing quality care that insurance doesn't cover.

Awareness of the need to reform these distorted incentives led in the early 2000s to increased interest in a "pay for performance" (P4P) approach that would reward providers for care that met certain best-practice standards. In 2002 the Robert Wood Johnson Foundation, together with the California HealthCare Foundation, kicked off an initiative—*Rewarding Results: Aligning Incentives With*

High-Quality Health Care—to test a range of P4P approaches. This five-year, \$8.9-million program was also supported by the Commonwealth Fund and managed by the Leapfrog Group in Washington, D.C., which was founded by Fortune 500 and government purchasers of health care hoping to bring accountability to health care.

Seven organizations—five funded by the Robert Wood Johnson Foundation and two by the California Healthcare Foundation—were selected to run demonstration projects: Blue Cross Blue Shield of Michigan, Blue Cross of California, Bridges to Excellence, the Excellus Health Plan/Rochester Individual Practice Association, the Integrated Healthcare Association, Local Initiative Rewarding Results (for babies and teenagers covered by Medicaid), and Massachusetts Health Quality Partners. The idea was to provide incentives for quality and investing in the expensive infrastructure needed to help improve quality. The seven Rewarding Results projects would set goals for achieving certain best practices, evaluate performance, make these measures public, and reward providers for providing appropriate care. The program used a broad range of strategies, such as making bonus payments for reaching specified performance goals (for example, hemoglobin A1c testing for people with diabetes), providing educational benefits, and helping doctors with the cost of installing information technology.

“P4P is meant to encourage providers to get systems in place and implement best practices,” said Leapfrog’s Chief Operating Officer, Karen Linscott. “We have to get current best practice incorporated into everyday practice, but that can take up to 17 years. We think incentives can help to motivate providers to decide to move more quickly.”

One example of how the program works is Bridges to Excellence. The coalition collaborated with the National Committee for Quality Assurance to develop best-practices standards for treating diabetic patients (such as checking kidney function, feet, eyes, and blood-sugar levels), and started using them in three cities: Boston, Cincinnati, and Louisville, Kentucky. Physician groups that met those standards were eligible for a bonus. The incentive apparently worked; Bridges to Excellence doctors were able to see twice as many diabetic patients as they had before, and costs declined 15 to 20 percent.

“These projects add to the mounting evidence that rewarding good performance can encourage doctors to provide appropriate care to patients to help them live longer and healthier lives,” said Karen Davis, president of the Commonwealth Fund. Even so, the approach has its critics. They question whether doctors will, in effect, be penalized if their patients don’t follow through on quality measures—don’t have bloodwork done, for example—or whether P4P will hamstring doctors by forcing them to stick to guidelines and not strive to find better solutions for their patients.

Suzanne Delbanco, Leapfrog’s chief executive officer, observed that the demonstration projects, although far from conclusive, provided “some of the first tangible evidence that P4P incentives can raise the quality of patient care.” She cautions that it is still too soon to endorse P4P and that more assessment is needed. Leapfrog’s materials caution that P4P “is not a magic bullet,” but just one of many efforts to try to address the need for better incentives in financing medical care.

To most observers, Rewarding Results—along with the similar experiments funded by the federal Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services—contributed some knowledge to the debate and amounted to a first stage of learning about P4P. As of the end of 2006, P4P took on even more importance, with the Centers for Medicare & Medicaid Services’ announcement of 1.5 percent bonuses to physicians who report their performance on certain quality standards.

Patient-Centered Care

With nearly three-quarters of health care spending now going toward chronic illness care, the need to figure out how to get patients engaged in their own care—even shaping it—has become critical. The IOM’s *Quality Chasm* report declared that in the redesign of the health care system, patient-centered care and patient self-management should play major roles. This is a fundamentally different approach to patient care than the traditional one. It signifies a collaborative effort between patients and physicians (and their health care team). For their part, patients—especially those with chronic conditions—must play a role in managing their illness by taking their medications, eating properly, exercising, and doing those things that will maintain their health. For physicians and their teams, it means taking time to understand their patients, educate them, and help them through whatever prevents them from following a healthful regimen.

Besides the patient-centered aspects of the Pursuing Perfection grants, the Robert Wood Johnson Foundation supported a number of efforts intended to help promote progress in patient-centered care, some of which are described below.

Quality Allies/New Health Partnerships

Quality Allies: Improving Care by Engaging Patients is a \$3.5-million, three-year initiative, co-funded with the California HealthCare Foundation and managed by the Institute for Healthcare Improvement, to help outpatient providers develop effective collaborative approaches to working with patients and their families to support them in self-managing a chronic condition. In an earlier companion pilot program, six provider teams, along with expert faculty, developed a curriculum to help guide the way self-management support could be given. It entails providers talking to patients about their interests, values, and preferences in a way that encourages them to become engaged in planning their own care. Providers then must follow up with patients to see if the plan meets their needs or requires tweaking.

“Self-management support tends to be the main driver in being able to achieve high-quality outcomes and process measures for people with chronic health conditions,” said Doriane Miller, a physician and former Foundation vice-president, who directs Quality Allies. “But in some medical circles this could be considered heretical, in that the doctor is always right and patients come to the doctor as a learned adviser, not as a collaborator.”

In 2005, 20 practitioner teams from around the nation were chosen to work for one year on collaborative self-management projects of their choosing, applying concepts developed in the pilots. Each team had to have a patient and a family member as an active planner of the project to gain the patient perspective.

For example, Harlem Hospital in New York City helped people with HIV follow medication recommendations and keep doctor appointments. A Santa Clara Valley Medical Center team in California developed better outreach and support for people with depression. A multiple sclerosis clinic at the Medical College of Georgia found ways to teach patients to use an online self-management support Web site so their doctor could help them manage their symptoms. In Fargo, North Dakota, an online portal was set up for people with diabetes to talk with one another about their medical problems and concerns, gain support, and create a sense of community.

Patients and family members have reacted well to Quality Allies, and processes of care for self-management have improved, Miller said. She noted that in some cases, the teams were able to help health plans and providers make a business case that by improving their care systems, they were better able to meet HEDIS care indicators—and could negotiate a higher rate of reimbursement for their services. Whether these sites will be able to sustain changes for the people who participated is yet to be determined.

The Quality Allies program, which was absorbed into another Institute for Healthcare Improvement program called New Health Partnerships, turned to its next phase—a distance learning program—in March of 2007. New Health Partnerships allows for the transfer of knowledge gained from the demonstration projects to a wide audience on the Web. New Health Partnerships set up two Web sites, one offering information and interaction for patients and families, the other providing a broad array of assistance for physicians. “We’ve had 26 organizations that have had face-to-face demonstrations,” Miller said. “There is a need for this to spread in a practical way. Demonstrations are labor-intensive and costly and not as efficient in terms of making sure we get widespread changes.”

Developing a Patient-Activation Measure

The Foundation also funded research that led to the creation of a “patient activation measure” by Judith Hibbard, a professor at the University of Oregon and noted quality expert. She developed the measure to predict how people with chronic conditions can be expected to behave—from doing healthy things for themselves to managing specific diseases to preventive efforts such as using quality information.

The answers to the 13 questions in the patient activation measure can predict the degree to which people have the ability and the confidence to manage their own health and health care. It can predict, for example, whether someone probably will or won’t follow medical advice to take medications and to exercise. Hibbard’s research has identified four stages on a person’s way to becoming a competent self-manager. Using the patient activation measure will help physicians and their teams customize their approach to involving patients in their own care. “It’s really about using this as a guide to think about the challenges people face at each of the stages,” Hibbard said.

Advocacy

In another patient-centered grant, the National Partnership for Women & Families is marshalling consumer and patient advocacy groups to become a stronger voice for changes to the health care system that will improve the quality of care. Begun in 2004, the program reaches out to local grassroots organizations as well as national advocacy groups. The partnership gives technical assistance to local groups, such as Easter Seals chapters and local clubs, helping them understand how the current debate on health care quality improvement affects them and how to become engaged participants. On the national level, the partnership works with groups such as the AFL-CIO, Consumers Union, and the National Coalition for Cancer Survivorship, to make sure that their efforts of quality and transparency meet consumer needs. Measurement, for example, is an important issue for consumers but often falls short of what they need. “We push the envelope and get to measures that will help us better understand outcomes,” said Debra Ness, president of the partnership. “There are a lot of measures that would be more meaningful to consumers than what we now have. That’s why consumers have to make sure they have a voice.”

The Next Steps: Linking Quality and Equality

By 2005 many of the strands of the Robert Wood Johnson Foundation’s work to improve quality of care were coming together. Through its work with the National Committee on Quality Assurance, the National Quality Forum, and other groups, the Foundation had assisted in the establishment of standards against which businesses and the public could measure the performance of health plans, hospitals, and physicians. It had funded the development and expansion of the chronic care model, which became a key component in the delivery of high-quality care to chronically ill people and a basis of pay-for-performance incentives. It had financed approaches in Pittsburgh and elsewhere that brought modern business practices to health care, including nursing care. Its support of palliative care had given dying patients and their families a greater say in the kind of care they chose to receive, and it had supported other efforts to make health care more of a joint effort involving patients and health care professionals.

The next step was to weave the strands into a tapestry that would enable communities to quicken the pace of improvement and do so on a larger scale than they otherwise could have. The Foundation decided to do this initially through a strategy focused on regional health care markets. In 2005 the Foundation launched *Aligning Forces for Quality: The Regional Market Project*. A \$14-million program managed by the Center for Health Improvement in Sacramento, it awarded grants to 14 community-wide coalitions of local stakeholders—physicians, insurers, hospitals, employers, and consumers. They are bundling three important components of quality: (1) enhancing transparency by measuring and publicly reporting on local physicians’ performance, (2) creating the local infrastructure to help physicians improve their outpatient care, and (3) generating consumer engagement by using quality measures to choose high-performing providers.

“We’re trying to break down the silos of the stakeholder organizations and meet our three aims,” said Gregg Shibata, the center’s associate director. “We want there to be no line separating quality improvement and transparency, and no line between consumer engagement efforts and transparency.”

Even as *Aligning Forces* was getting underway, the Foundation's board of trustees took a dramatic step. In 2006 it decided to consolidate the Foundation's grantmaking into a single priority area to improve quality and to decrease disparities.

For many years the Foundation had financed projects with the goal to reduce disparities in health—and in access to quality health care—between disadvantaged minorities and whites. Minorities have higher rates than whites of cardiovascular disease, diabetes, some cancers, obesity, and many other illnesses and unhealthy conditions. Many of the programs to reduce disparities involved research, but others attempted to improve the care received by African Americans, Latinos, and other ethnic minorities.

In combining its quality and disparities programming, the Foundation brought together its work in both areas. The new strategic priority area is called *Quality/Equality*. Very quickly, the Foundation's Quality/Equality Team began to consider how to apply the tools of quality improvement to the challenge of health care disparities.

An example of the kind of programs the Foundation plans to support under the *Quality/Equality* rubric is *Expecting Success: Excellence in Cardiac Care*, a four-year, \$13-million initiative involving 10 hospitals that the Foundation authorized in 2004. The program is focused on ensuring that African Americans, Latinos, and other minorities receive the same standard of quality care for cardiovascular disease that whites receive—for example, receiving beta blockers in the event of a heart attack. All of the grantee hospitals, which have formed a collaborative to learn from each other, are also encouraging quality cardiac prevention and care in the surrounding communities.

End Note

In recent years, Donald Berwick and a host of other leaders of the quality movement have spearheaded progress toward redesigning the array of systems that make up American health care. By 2007 the first stage of the quality improvement movement was ending, with advances achieved in setting measurable standards for performance, re-engineering hospitals to make quality and safety top priorities, exploring pay for performance, and finding ways to put patients at the center of their own health care. Although these changes have not been widely adopted throughout the country and the insurance system remains skewed toward reimbursing costly, high-tech curative care, they are being followed in a number of places.

The Foundation has acted as something of a midwife to this movement, providing the financial support and influence to help most of the major players carry out much of the early important research, experiments, and demonstrations on quality. Its resources have been directed at many separate aspects of the problem, but an overarching approach that brings all of the forces together appears to hold the most promise.

Now this movement heads into its next phase. For many of those involved it is like remodeling a house while still living in it—they are antsy, impatient, and sometimes don't see much progress or are disappointed by setbacks. But there is recognition, too, when all is said and done, that signs of

change are adding up and there's much to cheer about—from the development of quality improvement leadership to a recognition of what the problems are and from doctors' offices with new information technology systems to health plans that have begun to inject quality measures into their payment reimbursements.

“We have managed over the last few years to break down a lot of myths about how health care can't get any better, that it's just the way it is, [that] there are always going to be errors,” said the National Quality Forum's Janet Corrigan. “People realize now that it doesn't have to be this way. We can make it a whole lot better.”

Notes

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