



Robert Wood Johnson Foundation

Building Bridges to Better Health Care:

How America Will Improve Its Quality of Care



[President's Message](#) from the 2007
Robert Wood Johnson Foundation
Annual Report

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The stories real people tell about our health care system are very different from what we can and should deliver. We seek to change that. The photographs and stories that follow give voice to what has to change.

alignment:

(NOUN): the orientation of two or more parts of a machine or structure, especially parts that should be parallel or in line with each other

I was blessed to have parents who were physicians. Their dedication to their patients was the kitchen-table soundtrack of my early life.

We lived in Seattle and I can still hear my mother, a pediatrician, and my father, a surgeon, worrying about people who couldn't afford health care, kids who'd never had a medical exam or been to the dentist, and mothers dying because they couldn't get the hospital care that would have saved their lives.

As if it were this morning, I recall their frustration over disconnects and disputes between the people who required care, the people who provided care, and the people who paid for the care. It sounded sometimes as if they didn't have anything to do with one another at all.

Much has changed in a generation. There have been tremendous gains, but something has also been lost. Back then, doctors like my parents were the real linchpins of care; they literally held the whole thing together. Ask your own parents or grandparents and they'll tell you that the relationship between patient and physician was everything. When I was growing up, patients were a personal, physical presence in my family's life. They are what drew me to medicine in the first place.

It was a time when doctors, mostly old-fashioned fee-for-service solo practitioners, provided patients with a medical "home" where they could count on compassion, comfort and, yes, even house calls.

Families often stayed with a single doctor across generations, with the same physicians birthing the babies and attending to the end of the grandparents' lives.

Insurers, bureaucrats and technology had yet to take over. Nor was "quality" the data-driven model of measurement and evaluation it is becoming today. Instead, patients considered care to be pretty good so long as it anticipated their needs and was sympathetic to that intense vulnerability we each feel when we're really sick.

Hospitals for the most part were local, autonomous and nonprofit. Their own bosses, they set their own agendas, catering to special constituencies and functioning much like a self-protected local cottage industry.

Beneath this rose-colored veneer was a "non-system" that was capricious, complicated and seeded with the problems of quality, cost and unfairness that still confound us today. Policy and academic specialists were convinced that the biggest problem facing health care was not that people were getting too much care but that they were getting too little care. The real problems—uneven performance, subpar quality, variations in patient care—were unknown, ignored or overlooked.

This was the health care world that awaited me when I went off to medical school in the 1970s, not yet realizing just how much things were about to change.

living with a chronic condition

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Everyone that has diabetes knows it's a full time job managing the condition. Every day, from the time you get up to the time you go to bed, you are concerned with your blood sugar levels. Having diabetes impacts every area of my life—when I leave the house, when I am driving, everything I do. The numbers have to be right, not too low or too high. I've had my levels as low as 32—normal is somewhere between 90 and 120—and it's scary because it can happen anywhere, and fast.

Reverend James Gray
Pittsburgh, Pa.





fact { The United States spends more than
\$2 trillion a year on health care—16 percent
of our Gross Domestic Product, or \$7,026
a year for each one of us.¹



The small Vermont towns of Middlebury and Morrisville are separated by a two-hour drive up State Road 100 through the heart of the state's historic Green Mountains. These mountains are made for exploration.

On peak fall foliage weekends SR 100 is jammed with tourists. In the winter, it is skiers headed for Sugar Bush, Mad River Glen and Stowe. One bygone year it was a restless group of my fellow Harvard medical students, eager to scale something other than the jagged academic peaks back in Cambridge.

Middlebury is the quintessential upscale New England village (pop. 8,100), a famous college town complete with covered bridges, a classic country inn and enough year-round residents with postgraduate degrees to fill an 800-seat theater. Most folks who live here work here; it's been that way for a long time.

Morrisville (pop. 2,000) is less picturesque and more hardscrabble, with less money, less education and more kids per household than Middlebury. Many local residents work in the state capital, some 30 miles away. Higher education here is a branch of the state's community college, with offices in a former hardware store just before you get to the Price Chopper on the way out of town.

Something else beneath the surface separates the two towns. To find it, you might have to dig deep into research that feels complex and dry at first, but holds some fascinating stories.

A landmark study of medical care in Vermont conducted more than 30 years ago found that only 7 percent of the kids in upscale Middlebury had their tonsils removed. But in Morrisville, a whopping 70 percent of all kids had tonsillectomies.²

Why the big difference? Something to do with different levels of income and education? Did an epidemic of tonsillitis sweep through the Morrisville schools? Did parents in Morrisville take better care of their children than parents in Middlebury?

The answer turned out to be none of the above. In Morrisville a small medical practice of only five doctors was unusually aggressive in removing youngsters' tonsils. It was that simple.

With that 10 to 1 removal ratio, you would think that the kids in Morrisville would be healthier than all those kids in Middlebury. But they weren't any healthier; they just received more health care.







quality care matters



My relationship with my physician does matter. My last doctor treated my father, and he knew the family very well, that hypertension and diabetes ran in the family. At one point my medication was overlapping and he told me that the insulin was staying in my body, so I needed to split up the medication to give it time to process. Because he knew the history, he was able to provide better quality care for me.

Reverend James Gray
Pittsburgh, Pa.



fact { Poor quality care leads to as many as 45 million avoidable sick days.³



fact

{ All Americans are at risk of receiving poor care regardless of where they live, how much money they have, or their race, education or health insurance.⁴

The two investigators were puzzled by the disparity; it had to be an anomaly. To find out, they eventually examined health care practices throughout the state's 16 hospital service areas spread across 251 towns and villages.⁵

Wherever they turned, the researchers found variations like the tonsillectomies that had nothing to do with patient need or demand. Instead, many doctors and hospitals practiced the principle that more care is better care, without scientific follow-up to test if that was, indeed, the case. As we now know, all that extra care often results in the delivery of care that is not needed, that wastes resources, and that can be dangerous.

The startling discovery of irrational variations in care set off shock waves that continue to ripple through the worlds of patient care, health care research, and our own philanthropic efforts to improve the quality of health care across the country.

The medical detective-scholars were earnest young graduates of Johns Hopkins School of Hygiene and Public Health named Jack Wennberg, a physician, and Alan Gittelsohn, a biostatistician.

They were disciples of the godfather of health services research in America—Kerr Lachlin White—himself a physician, epidemiologist, economist and early giant in the study of medical care utilization. He's the one who initially showed the University of Vermont how to install a system to harvest patient data from hospital discharge summaries all across the state.

White was applying what he was teaching at Johns Hopkins, where he was training the advance corps of a whole new type of medical researcher, including Wennberg and Gittelsohn. He equipped them to assess both the medical and the social conditions of health care and its effects on real patients in real hospitals and community settings. And, with National Institutes of Health grants, he made sure they had the technological hardware and software to do the job.

I tell this story because Dr. White was one of my early heroes as I came to understand the complex relationships between medicine, health care delivery and health policy. His thinking continues to inform my own in shaping new ways the Robert Wood Johnson Foundation can help improve health and health care.

It has also helped inform a radically different approach to bettering the delivery and the quality of health care that is outlined in this message. It is an evidence-based approach that calls on communities to bring their own local health care forces into a new alignment of mutual interest and effort to help people get better care.

The intellectual roots of our work trace directly back to Kerr White, who saw clearly that localized patient care research was the key to understanding how health care works, or does not work, in a particular locale with a particular population.

Perhaps it is no coincidence that the same year Wennberg and Gittelsohn started their breakthrough work door-to-door in Vermont, Nobel scientist and transplant trailblazer Peter B. Medawar wrote, "If politics is the art of the possible, research is surely the art of the soluble."⁶

It follows, I would add, that philanthropy is the art of investing where the returns are measured in benefits to society—often because useful learning and action are achieved when special interests, political complexities, inadequate leadership or a hodgepodge of players put up barriers to resist change.

Which brings me to the rest of the Vermont story. Once the findings from Wennberg and Gittelsohn's work began to soak in, a "don't blame us" faction of organized medicine and individual physicians pushed back against the findings. They counter-argued that any inconsistencies in care merely reflected different patient conditions and needs. As a result, the Wennberg-Gittelsohn paper, "Small Area Variations in Health Care Delivery," was rejected by every major medical journal in the country.

Not until six years after they began their work did *Science* magazine finally publish their manuscript⁷ (scrunched between articles on the authenticity of the Nixon Watergate tapes and the link between birth order and IQ among young Dutch males). The paper endures as a seminal work of social-scientific discovery. It still reads with the crisp relevancy of unvarnished scientific truth.

Gittelsohn eventually returned to Baltimore, while Dr. Wennberg's worn and wrinkled road map led him to Hanover, New Hampshire, and Dartmouth Medical School, where he invented the now-famous *Dartmouth Atlas of Health Care*.

RWJF over the years has invested heavily in the *Atlas*, helping provide the resources and staying power for the team at Dartmouth to refine the once-struggling art of health services research into high science.

At first their data stream was a trickle, then a torrent. Complemented by the efforts of others, they continue to sharply map the realities of America's health care landscape and make clear the best pathways to improvement. We rely heavily on the *Atlas* as we push hard against the quality frontier.

Three things stand out when you examine the map. No matter the terrain, most roads lead to regional and local solutions. Obstacles and pitfalls blocked early progress. Visionary pioneers like White, Wennberg, Don Berwick and Ed Wagner have cleared much of the way by challenging, disrupting and then changing the status quo.

For example, Berwick's Institute for Healthcare Improvement directs our national programs to show doctors, nurses and hospitals how to make significant improvements in caring for patients. The result: People receive better, safer care and have closer relationships with their doctors.

Wagner heads *Improving Chronic Illness Care* (ICIC), another RWJF national program. Right now, ICIC-trained medical and nursing teams in hundreds of hospitals and clinics are following Wagner's evidence-based Chronic Care Model to keep people healthier and out of the hospital in the first place.

Pathfinders like Berwick, Wagner and others are showing the country how to shift from a system of incredibly expensive acute or "sick" care to a more effective, less costly, higher-quality system of chronic care.

The going has not been easy or swift. Health care's status quo has long been suspicious of innovation related to quality improvement, distressed by scrutiny and dead-set against public accountability. Truly transformative change demands a different approach, one based on tested, proven and trustworthy evidence of what it takes to demonstrably improve and sustain the quality of medical treatment and patient care.

Health care in America has reached its own tipping point, what Malcolm Gladwell describes as "the moment of critical mass" preceding explosive change and *TIME Magazine* calls "the levels at which the momentum for change becomes unstoppable."⁸

It is evidence—the data—that builds the critical mass. Until recently, extensive data on how hospitals and physicians actually meet patient needs was nonexistent. No wonder that "health care" and "quality" have been so mysterious to most people for most of their lives. The professionals who provided it couldn't explain it themselves.

In the past decade, however, data streams measuring quality matured and deepened from sources as varied as Dartmouth, Medicare, the U.S. Department of Veterans Affairs, the federal Agency for Healthcare Research and Quality (AHRQ), state governments, business groups and consumer advocates.



Also new on the scene is the public-private National Quality Forum (NQF), comprising nearly 500 organizations representing most major players across the health care sector's full spectrum. Through NQF, they are agreeing to act together on priority health quality issues where the need to measure and improve care is most urgent.

Put it all together and the once-barren quality landscape is becoming an abundant field. As a result, "quality" has become an evidence-fueled engine for the improvement of every aspect of health care delivery and financing. And it doesn't always have to be high-tech.

fact { More than 1.5 million
medication errors are made
each year.⁹

working together on chronic care



One thing about a chronic condition is that it's scary. When you have been sick for a long time, you can get tired of going to the doctor and taking medications. You need people around you who care. A concerned doctor helps. My current doctor told me, "we're going to get you better and attack this one thing at a time." Along with my faith and family, that keeps me going.

Reverend James Gray
Pittsburgh, Pa.





collaboration:

(NOUN): the action of working with someone to produce or create something

Sometimes all it takes to improve care is a clipboard and a will to work in a new way. That's how Dr. Peter Pronovost recently reduced dangerous infections among ICU patients at hospitals in Baltimore and Michigan.

Pronovost is a critical-care specialist who runs the Center for Innovation in Quality Patient Care at the Johns Hopkins School of Medicine. (Yes, echoes of Kerr White).

Troubled by the incidence of infections among his ICU patients, Dr. Pronovost wrote down on plain paper a set of steps to avoid infections when putting an IV line or catheter into a patient. This checklist was simple stuff medical staff knew they should do but few rigorously followed, such as washing hands with soap, placing sterile drapes over the entire patient, wearing a sterile mask, hat, gown and gloves.

At first colleagues and management scoffed at the notion. But over the next two years, that checklist—along with the professional tenacity of nurses—showed a significant decrease in the number of infections and deaths and saved the hospital \$2 million. This was huge. Dr. Pronovost became a man on a nationwide mission, showing up at as many as seven hospitals a month to pitch the proven benefits of ICU checklists.

Hospitals and doctors at first treated him like an eccentric on an impractical, quixotic quest for the unattainable. Nurses, however, got it right away. When Dr. Pronovost asked them to observe doctors inserting lines, within a month they found missteps about a third of the time. Nurses became instant checklist champions.

As the word spread, Michigan's hospital association put checklists to work in their own ICUs. Though federal regulators later questioned technical aspects of how the follow-up research was conducted, they did not challenge the use of checklists to improve the quality of care. In fact, participating Michigan hospitals estimated that within 18 months the checklists saved 1,500 lives and an estimated \$175 million.¹⁰ As an ancient African adage says, "with a little seed of imagination you can grow a field of hope."

This is quality improvement at its most dramatic. Pronovost's elemental use of a checklist and clipboard turned him into a national leader in applying clinical research to improving the quality of care. He's received the John M. Eisenberg Patient Safety and Quality Award in Research Achievement (named for the late founder of AHRQ and a dear old friend and mentor). Atul Gawande, one of the foremost writers on health care today, highlighted Pronovost's work in one of his feature stories in *The New Yorker*.



meeting the quality challenge in different environments



Working in an urban environment means that I see more patients with chronic conditions like asthma, diabetes, stress, high blood pressure. I think about how I can respond to these factors as an individual doctor, but I also think about how this local health care system could be better designed to address these circumstances.

Mark Rabiner, M.D.
St. Vincent's Hospital
New York, NY



In many hospitals, however, institutional resistance to such a simple lifesaving exercise remains significant. Dr. Pronovost explains that “the fundamental problem with the quality of American medicine is that we’ve failed to view delivery of health care as a science.”

Medical science has three core tasks, he says. They fall into “three buckets:” (1) understanding disease biology; (2) finding effective therapies; (3) delivering those therapies effectively.

“The third bucket has been almost totally ignored,” he says. “That’s a mistake, a huge mistake.” At RWJF, we are working with old friends and new partners to fill up that third bucket.

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“Collaborate” is the key word. Without collaboration, the financial, clinical, professional and personal forces that frame our health care universe will continue to struggle with many of the same old pieces

of the same old health care puzzle. In the absence of cooperation and partnership, it is not surprising that after all these decades of trial and error, failure and neglect, the pieces still don’t fit.

I know from my own personal observations at a community clinic in New Jersey that people worry about getting good care and are put off by too many choices. There’s not enough clear, trustworthy information. Too often process rules over professionalism, with payers and health plans an intrusive presence in the examining room.

People end up feeling that their doctors are so crunched for time they don’t get a chance to ask questions about their symptoms, treatments and medications. More than half of them fear something bad will happen to them if they go into the hospital. Research into medical errors says their fears are justified.

The so-called system sometimes seems so absorbed in taking care of itself that it doesn't seem willing or able to deliver the high-quality patient care that millions of highly trained and passionately committed health care professionals know how to provide. It doesn't help that outdated reimbursement schemes continue to pay providers for how much they do, not for how well they perform. And some health care professionals forsake the ethical tenets of their own professions as they contest payment proposals that would measure and publicly report on their performance.

Meanwhile, cost and coverage, not quality, dominate the national debate. Quality lacks drama, slick sound bites and high-profile public champions. More difficult to explain, quality gets short shrift from elected leaders and is short-changed by the media.

In curious discordance with the evidence, the political refrain often is "we have the best health care system in the world." But the personal and family experiences of two-thirds of all adults—66 percent—leave them "dissatisfied" with the quality of health care, according to a noteworthy CBS News opinion poll last fall.¹¹ And international research consistently indicates that we lag behind other major societies in delivering timely and effective care, in patient care outcomes and in the overall health of our people.

America's infant mortality rate is the highest among 23 nations. Our teenagers are the most obese adolescents in the world. We are the only industrialized nation without universal health coverage. On key measures like access, quality and efficiency of care, we rank last or next-to-last in a comparison with five other countries (Australia, Canada, Germany, New Zealand, the United Kingdom). Health care providers in the United States are far behind their colleagues in other modern countries in using information technologies like electronic medical records.¹² The U.K. annually spends nearly \$193 per person on health information technology; the United States spends 43 cents per person.¹³

As Kerr White's Green Mountain Boys found in Vermont, to this day the facts and figures of health care vary wildly no matter how we measure, whether by geography, clinical taxonomy, what it costs or what it achieves. What does *not* vary is the solid evidence that money alone cannot buy quality. We're spending more than \$2 trillion a year on health care—16 percent of our Gross Domestic Product, or \$7,026 a year for each one of us¹⁴—yet it makes little measurable difference in the effectiveness of care or in better patient outcomes.

Why not? A big reason is that there is not yet a single well-functioning regional health care market in all the country. Not one.







fact { Tens of thousands of Americans
die each year as a result of
preventable hospital errors.¹⁵



understanding the barriers to quality care

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I think medical professionals need to understand the many barriers that may prevent a patient from getting good-quality care. For example, a patient may get to an emergency room only when his or her condition has reached crisis point. When this happens, you can recommend all of the right things to do as next steps—like follow-up visits, or new medications—but that

patient maybe can't afford drugs, or has other things going on that prevent good follow-up care. Many of these kinds of patients are labeled "noncompliant," when really, it's not about compliance at all.

Mark Rabiner, M.D.
St. Vincent's Hospital
New York, NY





The dots are not getting connected. We know. We've spent time and resources searching for even one effective market. It is not to be found.

We intend to change that. We're going to connect the dots.

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In April 2007 the Board of the Robert Wood Johnson Foundation reached this pivotal conclusion:

No one entity or edict can, on its own, affect the quality and nature of patient care across all its dimensions and sites . . .

What the nation needs now is sustained collaboration, at the local level, toward a shared and ambitious goal of high-quality care.

Here's the context: Yes, national health system reform may sound good as a lofty concept. For years we've heard that the answer to reform is through incremental government action by way of legislation, regulation and executive edict.

Tinker around with enough small changes, this school holds, and somehow the whole system will be healed. The evidence, however, suggests that piling project upon project may accumulate great weight from the top down but does not lead to system change.

As all the data makes clear, in reality there still is no national "system" of American health care (aside from Medicare and the Veterans Health Administration).

Sure, the collection and analysis of data mined nationally is vital to identifying best practices and consistent national standards of care. National disease, health care professional and trade organizations also give an important voice to those with specific experience, expertise and insight. Nonprofits like the Commonwealth Fund and the Kaiser Family Foundation provide a valuable national service by organizing and disseminating important information.

However, improving the quality of patient care itself is not an abstract, academic or figurative concept. It is a hard reality that can take place only at the precise point where patient care and real patients converge. That happens locally, where families live, work and play, where they know their physicians and trust their hospitals.

Fortunately, the fraying threads that lace together health care's fragmented segments are still intact in our communities. Here, the evidence suggests, it is still possible to influence all those different forces that shape exactly what health care is, how it's delivered, who gets it, what it costs, and how well it works.

Down home—this is where we can fill Dr. Pronovost's "third bucket."

empowering the disempowered

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I let the patients know that I'm there for them, to serve them, and to provide them with medications and health care. I educate them about what the disease process can lead to and speak to them in a language they can understand. They are an active participant in their own care. I've known some patients as long as nine years. I don't just hand them a pill, but I explain to them why and how they can take control of their health.

Mark Rabiner, M.D.
St. Vincent's Hospital
New York, NY





quality:

(NOUN): the standard of something as measured against other things of a similar kind

(NOUN): general excellence of standard or level

In 2007 we launched the first phase of *Aligning Forces for Quality: The Regional Market Project*, a long-term, multimillion-dollar commitment to help a number of test communities re-weave the fabric of their own local health care system into a stronger, more resilient, higher-quality tapestry of care across its fullest continuum.

The delivery and quality of health care is determined by a mix of factors unique to each distinct locale. Coast-to-coast, many of the problems may be common. But market-to-market, the solutions are not. What works well in one region may not work at all in another. Though each community struggles to find its own answers, so far none have succeeded.

The reasons are varied and complicated. Progress may be impeded by tough, even adversarial competition among providers. Some stakeholders may not know how to talk to each other. What is best for patient care may be overridden by the corporate focus on the bottom line, especially in uncertain economic times. The absence of commonly accepted standards of quality care may make accountability for providers' practices and outcomes difficult. And the lack of clear, reliable public reporting on hospital and physician performance leaves patients and consumers perpetually in the dark.

Put simply, forces and factors that should be in alignment are out of alignment. Our new program will help local and regional health care leaders and stakeholders realign themselves to provide their people and communities with better quality health care.

We call it **AF4Q**. This is not piecemeal, incremental, short-term (and unsuccessful) health system reform as usual. It has no politics or partisanship of its own. If it did, it wouldn't work and we wouldn't do it. Rather, it is an unprecedented regionally determined clinical, social and economic market realignment that calls upon enlightened and aspirational local leadership, intentional collaboration, reliance on evidence-based action, public reporting and accountability, and public participation in deciding how quality health care is delivered to the community.

AF4Q is a first-of-its-kind effort that is as much a call to community action as it is a potent formula to bring the best possible medical care and peace of mind to as many people and their families as possible.

Each **AF4Q** community is typically American and typically one-of-a-kind. They include significant urban-suburban centers, small stand-alone cities, exurban and semi-rural counties, even entire states. Differences in geography, history, demographics, economics, politics and social structures would suggest they have little in common.



practicing and practitioning

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I work in a nursing home and I see a lot of complications from diabetes—renal failure and people on dialysis, heart problems and it's all from being diabetic. Diabetes is a whole body thing. And I think about myself and I think, that could be me somewhere down the road.

And it's scary. I don't want to be like that so I want to try to change things now before I'm that old. I don't want to have to be on dialysis and I don't want my kids to see me like that. My daughter tells me to meditate to bring my anxiety down. We try to take walks at night as a family but it's hard to build it into

the schedule. Things don't always fall into place in day to day life. If we exercised together it would make us closer as a family.

Frances
Patient and nursing student
San Xavier Health Center
Tucson, Ariz.

These are some of the pioneering communities taking part in AF4Q Phase One:



Cincinnati, Ohio

Cleveland, Ohio

Detroit, Mich.

Humboldt County, Calif.

Kansas City, Mo.

Maine

Memphis, Tenn.

Minnesota

Seattle, Wash.

Willamette Valley, Ore.

Wisconsin

Western Michigan

Western New York

York, Pa.

We will be expanding the scope and scale to include several additional sites later this year.



Yet, there are dynamic similarities. Each region has one or more energetic, self-motivated entities already working on their own to give people better care. In one community it may be physicians, in another the hospitals, in a third the business community. Many players are proven veterans of teamwork and predisposed to collaboration. All want to deliver better care.

As the organizing philanthropy, we are the catalyst that motivates and mobilizes **AF4Q** regional stakeholders with a shared vision and common goals. We help develop their leadership, support them with expertise and resources, and guarantee to stick with them until momentum is secured, their own benchmarks are met and success achieved, as determined by evidence and evaluation.

AF4Q is not realignment by top-down edict but by bottom-up leadership and innovation. Decisions, actions and accountability are in local hands from start to finish. It is up to community, civic, health care and business leaders—and the people themselves—to agree on their own quality improvement goals and desired outcomes. This is their trek; we are merely the sherpas.



Our vision of the way forward is framed by our understanding that quality of care improves (1) when providers cooperate in a system that is safe, fair, inclusive, and devoted to getting it right; (2) when providers openly report to the public how they measure up to quality performance standards; and (3) when people are well-informed and take an active role with doctors, nurses and hospitals in the management of their own care.

Aligning Forces communities are at work now. They are tailoring their strategies to conform to the regional scale of local solutions while matching the wider scope of an obviously national challenge. True trailblazers, they seek not small gains but improvements dramatic enough to trigger significant advances in quality that can be measured, replicated and built upon.

We feel fortunate to be supporting them. The lessons they are teaching us are encouraging enough that we can grow and expand these efforts. Like that long-ago study in Vermont, we expect **AF4Q** to stand as a beacon that illuminates health care's way far into the future.



raising a healthy family



My kids are healthy. And I keep them healthy by taking them to the doctor when they're sick. It's a long wait in the clinic. When you go to the doctor you're going to be there all day. I have five children. It was hard at first but my family helps a lot. I work, then I don't work, but they help. I just found out that the two youngest ones have asthma. I have to give them treatments every four hours to help them with their breathing.

Alysia

San Xavier Health Center
Tucson, Ariz.





fact { The U.S. infant mortality rate is the highest among 23 nations.¹⁶



"RECORD NUMBER OF STUDENTS APPLY TO MEDICAL SCHOOLS"

The Bloomberg.com headline caught my attention right away.

The story reported that the country's 126 medical schools attracted 42,315 applicants in 2007, the most ever. Nearly 18,000 students were accepted, also a record.

One associate dean explained that today's medical school applicants "are in a world that is changing and scary and unstable." In medicine, he said reassuringly, they see a way to "do something for the benefit of mankind."

It takes about eight years to become a fully functional novice physician, so today's new pre-med students will receive their M.D.s in 2015. That's not that far away; it is the same year we expect to have measurable results from **AF4Q**.

When this newest generation of physicians steps out into their profession we want them to find a realigned realm of health care that is vastly improved by the collective experiences of our **AF4Q** innovators. A world where . . .

- Health care works the way it's supposed to work.
- Health care is affordable, accessible, appropriate and equitable.
- The care that is delivered is the care that should be delivered.
- People choose care providers based on public performance information.
- Problems of quality, safety and inequality are fading memories.
- Safety and accountability are a given.
- The system centers on taking care of patients, rather than taking care of itself.

Creating this improved world is all about the art and science of discovery and change, familiar territory for the Robert Wood Johnson Foundation and the people, organizations and communities we work with. We believe improving quality is, indeed, the tipping point issue for health care in America.

How to fix health care has confounded the people of this country and our leaders for most of four generations. That includes every Congress from the 80th through the 110th and every president from No. 33, Truman, through No. 43, G. W. Bush. Each has tried and all have failed. The reasons are manifold, the culprits plentiful, and through the advancing political seasons the forces of divisiveness, cynicism, self interest, greed and gridlock seem to doom each new attempt before it barely gets off the ground.





community-based health care



My mom's diabetic and had a stroke in 2001. The doctors told her she wouldn't be able to walk again, but we stayed with her and she walked out of the hospital. Now we come to the San Xavier Health Center to get her medications and for her follow-up appointments. The Center is such an important part of our community and they help us stay healthy.

Rena
San Xavier Health Center
Tucson, Ariz.

fact { Americans receive only half of
the appropriate, evidence-based
care that experts recommend.¹⁷



This time, though, is different. This time a set of different forces are at play.

It has been said that “America is the civilization of people engaged in transforming themselves,”¹⁸ an awesome endeavor that demands vision, hard work, leadership and organization. In most other societies that means government.

In America, however, that more often means what Duke Law and Public Policy Prof. Joel Fleishman calls the “civic sector.” Not the public or the private sector, but a third and transformative force in how we as a people take care of ourselves. Philanthropy is at the civic sector’s center, taking private action for the common good in ways that public and for-profit sectors cannot or will not attempt. In other words, don’t *tell* us what to do—*show* us what to do—and *we* will do it.

In what reads like a mission statement for **AF4Q**, Prof. Fleishman says that foundations such as ours seed a problematic field with research and trials, clarify a vision for change, define clear and achievable goals, devise evidence-based strategies to get us there, recruit the partners needed to get the job done, and drive society toward the sweet spot on the horizon.

It is not our role to dictate what exactly should be done. But we can cultivate and maintain an environment that allows others to find common ground and agree on common action where none existed before.

We know how to do this. We have years of experience working with communities, power players and strange bedfellows. We know what it takes to turn wary competitors into enthusiastic partners capable of connecting the dots and trusting one another as they do it.

Our only agenda is the success of others in transforming their own spheres of interest and influence. Washington and the usual crew of insiders cannot do this. Philanthropy and the civic sector *can*. Informed by solid evidence, led by the best minds and tested leaders, and empowered by an informed public that expects—demands!—better health care.

This is hard work, social transformation down in the trenches, where far-reaching and consequential change must begin. Some will wish us well; some will not. Some will share our vision; some will choose not to see at all. Some will embrace quality and change; some will fight it; some simply will hide from it.



As for us, we turn to the time-tested wisdom of an old Nigerian tribal proverb, the one that tells us . . .

“In the moment of crisis the wise build bridges, the foolish build dams.”

Health care in America is in its full moment of crisis. As a people, we have a choice to make. Do we fight or do we flee? Do we build bridges or do we build dams? The Robert Wood Johnson Foundation is in the business of building bridges. We think America and Americans are too.

Respectfully submitted,

Risa Lavizzo-Mourey

Risa Lavizzo-Mourey, M.D., M.B.A.
President and Chief Executive Officer



AF4Q At-a-Glance



Regional Quality Team Members

Who needs to be on AF4Q local teams:

Patients and consumers of health care and their advocates;

Providers of care, including physicians, nurses, community hospitals, teaching hospitals, and community clinics;

Purchasers of care, including insurers and health plans, large employers, small businesses, and the self-employed;

The public sector, including local, county and state agencies, legislators, and regulators;

The public health community.



Objectives

Signposts on the way forward:

- 1 Quality improves across the full continuum of patient care.
- 2 The public gain a voice in how communities improve quality.
- 3 Providers willingly and publicly report performance and quality data.
- 4 People learn to use accurate and timely information to better manage their own individual and family health and health care.
- 5 Patient-centered care replaces process-driven care.
- 6 Provider organizations and institutions break down silos, share information, engage patients, and modernize hospital systems and workplace cultures.
- 7 Medical errors are reduced and lives saved.
- 8 The demand for acute “sick” care is lessened by better managing chronic medical conditions and promoting disease prevention.
- 9 Racial, ethnic and geographic disparities are reduced as standardized quality measures detect and track inconsistencies and inequalities.
- 10 Communications and coordination improves among hospitals, doctors, nurses and patients as silos break down, information is shared, and key players realign to work together.



Goals

What it will take to improve quality:

Quality: Providers improve their ability to deliver quality care.

Transparency: Providers measure and publicly report their performance.

Public Engagement: Patients and consumers recognize and demand better health care.



Key Tactics and Techniques

How it works:

Provide AF4Q communities with operations and communications assistance from a new RWJF national support center.

Link local and regional participants to other RWJF national quality programs, e.g., *Improving Chronic Illness Care*.

Build national consensus for consistent, shared standards of quality measurement and public reporting by enlisting the cooperation of national stakeholder organizations.

Measure both variations and similarities of patient care across the community with uniform, region-wide quality standards.

Institute public reporting from hospitals and physicians on their performance ratings.

Equip the public with information to help them determine the course of health care in their own lives and communities.

Strengthen the role of nurses at the bedside and include nursing in hospital executive decision-making.

Develop evidence-based counter-measures to reduce medical errors and more effectively manage chronic conditions.

Recalibrate internal practices and operations in local hospitals and regional health systems to focus on evidence-based, patient-centered care.

Reduce disparities in care as a requisite to quality improvement.

Measure. Evaluate. Fine-tune. Measure again.

Test new ways to reward providers for improvements in the quality of patient care.

Perspectives from the Field



Stories from the Change Agents

We often talk about quality in a very abstract way. For me, quality health care is a sense of security that you're going to get the care you need at the right time in the right place. It's a knowledge that there's going to be a team of people who will be sensitive to what you need, who can understand your concerns, and who will put in the time and effort to make sure everything is done in the best possible way to heal you, cure you, or at least relieve your pain.

About a year ago I had an experience that really opened my eyes to quality and what it does and doesn't mean. My 91-year-old mother was found confused and was taken to the hospital. My mother's an immigrant from Haiti, so she speaks Creole—she speaks English also, but as part of her confusion she was speaking only Creole. The doctors ran a lot of tests and finally decided they really didn't know what was wrong with her; therefore it must be something psychological or psychiatric. After two weeks of my mother being hospitalized, another physician came onto her case and asked, could there be something else going on here? This physician did more tests and found that she had a blood infection. Her condition was cured within weeks after being given intravenous antibiotics.

It was a story that spoke to me in a lot of ways. It spoke to the gaps in the system and it spoke to the biases and expectations that many of us, including physicians, bring to our encounters with patients. We have to get beyond that if we're going to provide quality health care.

Taking a regional approach to improving quality makes a lot of sense. Americans don't get health care nationally; they get health care down the street. They get it in their community. Also, patients go between various parts of the health system: doctor's offices, clinics, emergency rooms and hospitals, nursing homes. If the various parts are not on the same page in a region really bad things can happen. For instance, a patient leaves a hospital, they have a heart problem, and the information that people got about that patient while they're in the hospital doesn't follow that patient to the doctor's office or to the clinic. That can hurt; that can hurt real bad.

Patients don't know much about quality health care in America. They have a feeling about whether or not a doctor or nurse spends time with them and is responsive to them. But so many times I've seen patients who love their doctors even though that doctor really isn't practicing up-to-date medicine. People need to know that we now have ways of measuring how good doctors, hospitals, nursing homes, and other parts of our system are. They need to know that this information exists and to be empowered to use it. I think that's going to be a major agenda for quality over the next decade. Measuring quality and publishing reports about it.

Bruce Siegel
Research Professor, George Washington University
School of Public Health and Health Services
Program Director for the *Expecting Success* program



Anne Snowden
Director of Quality Reporting
Minnesota Community Measurement
Aligning Forces for Quality Grantee

I work for an organization that makes quality ratings on clinics publicly available so that consumers can make better informed choices regarding their health, and will ultimately improve health care quality. Public reporting is about recognizing medical groups and clinics that are doing well in health care and providing motivation for those who need it.

I have a great story that reflects why public reporting matters. I attended a recognition reception for medical groups in Minnesota that were top performers in our measures. There I met a nurse practitioner who expressed appreciation that our organization had added a Cancer Screening composite measure to our Web site—it measures the percentage of patients ages 50–80 who received all appropriate cancer screenings (breast, cervical and colorectal). She knew that results would be reported publicly and that their medical group would be compared to their peers. She said that this motivated her clinic leadership to add this measure to their internal goals. By doing so, they put systems in place such as reminders for physicians, patients and clinic staff to make sure their patients got all these cancer screenings.

She then told me about one of her patients who came in for a mammogram and they found an early stage breast cancer. This nurse practitioner was convinced that this patient would not have come in for a mammogram had the reminders not been sent. Her breast cancer was caught early enough that it made a difference.

You don't get to hear these stories every day. You don't hear that public reporting actually saved somebody's life. I'm grateful she shared this story with me and that she took the time to let me know that the work we're doing matters. Now I know that it mattered to one person. And I would guess that if it helped one person, it probably has helped many more. I'm so pleased with what we do. I really believe in it.



Ashish Jha
Practicing Internist and Faculty
Member at the Harvard School of
Public Health in Boston

Disparities in health care are particularly troubling. We know from the countless studies that have been done that blacks, whites, Hispanics, other groups receive very different health care. And even if we account for differences in access, insurance and income, we're still left with a pretty substantial gap in the care that people receive. As a practicing physician, I think I treat everybody the same. Well, guess what? Every doctor thinks that. And yet, somehow, when it comes to the actual delivery of care, our health care system ends up treating people very differently based on their race or ethnicity. I find that very troubling and it motivates me to understand why people get different care and how we can fix it.

A patient that had a profound influence on me was an elderly African-American gentleman I cared for during my residency. He had had an impressive career as a civil rights activist, had marched in Selma, and done terrific things in terms of advancing the civil rights agenda. And I had the honor of caring for him when he was very ill from metastatic lung cancer.

I worked tirelessly to keep his pain and nausea under control, to keep him out of the hospital so he could spend time with his wife and kids. I remember marshalling every resource I could, consulting all of my senior faculty, and yet, I felt like I was fighting a losing battle because I just wasn't able to care for him in a way I knew he deserved. He would get seen in the middle of the night in an emergency room, and no one would contact me. He would get seen by other doctors who wouldn't prescribe him pain medicines because they were worried he might become addicted. It was tragic.

It made me wonder how we, as a community, could do better. There were so many troubling things along the way, the way he was treated by others, by the system, that made me wonder if it was particularly more difficult because he was African American. And I think this experience really shaped me to think much harder about quality, pay more attention to inequities, and try to understand how these two things are connected. I know we can do better for the sick and vulnerable members of our society, regardless of their background or skin color. We need to ensure that patients, like the one I mentioned above, get the care they deserve.



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quality at the grassroots level



There are many people who have chronic conditions that are not being managed because there are just too many barriers to quality care.

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