



Robert Wood Johnson Foundation

Aligning
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EXECUTIVE SUMMARY

A Checkup on Health Care Markets

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

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

Institute of Medicine, *Crossing the Quality Chasm*¹

As part of *Aligning Forces for Quality: The Regional Market Project*, the Robert Wood Johnson Foundation (RWJF) and the Center for Health Improvement (CHI) studied key attributes of the health care markets in 14 communities across the country, seeking a better understanding of how to help communities drive and sustain high-quality health care for patients with chronic illnesses. The study found vast differences in the development of these individual attributes among the communities, underscoring the need to account for local and regional variations in any national effort to improve health care quality.

This report summarizes the study, which was based on in-depth “scans” of the 14 communities. These scans were undertaken to describe the key hypothesized components of well-functioning health care markets and then to assess and compare those components. This approach takes as a starting point the assumption that a collaborative, regional effort that emphasizes alignment of health care market forces is very likely the best practical way for communities to achieve sustainable health care quality and value. By assessing and comparing market components, the study gives communities specific areas to target for improvement.²

The study is based on themes and recommendations found in the Institute of Medicine’s *Crossing the Quality Chasm* as well as the advice of a group of national experts. It seeks to measure and compare the major attributes that well-functioning health care markets need in order to drive sustainable quality and value in the ambulatory care of chronic conditions. To this end, the study team conducted scans of 14 communities and scored them on seven attributes of market readiness using a tool the study developed called the “Market Readiness Matrix.” The seven attributes are:

- 1. Community Leadership.** This score was produced by asking key stakeholders in each community to assess their community’s leadership.
- 2. Quality Improvement.** This attribute calculated the percentage of the top 12 physician organizations and the percentage of federally qualified health clinics (FQHCs) that are participating in quality improvement collaboratives.³
- 3. Performance Measurement.** This attribute calculated the number of top health plans (based on enrollment and payer type) and top 12 physician organizations that are accredited and measuring performance using national metrics.

- 4. Public Reporting.** This score was based on whether performance measures are publicly reported and the extent to which physicians in the community are certified under the National Committee for Quality Assurance’s (NCQA) Diabetes Physician Recognition Program and Heart/Stroke Physician Recognition Program.
- 5. Provider Financial Incentives.** This score was based on the prevalence of incentive initiatives like the Bridges to Excellence program in the community and whether top health plans are individually implementing pay-for-performance programs.
- 6. Health Information Technology (HIT) Incentives and Infrastructure.** This attribute measured the degree of electronic connectivity among stakeholders; the presence of incentives to participate in these efforts; and the extent to which physicians in the community participate in NCQA’s Physician Practice Connections recognition program.
- 7. Consumer Engagement.** This attribute was based on the presence of health plans or employers factoring quality into consumer choices for selecting a provider.

There are four basic scoring levels for each market attribute—A, B, C and D—which may be thought of as optimal, good, basic and limited. Each component was based upon a ranking and a simple division of the numerator over the denominator. For example, in the Quality Improvement category, if six of 10 federally qualified health clinics participated in a diabetes collaborative, the component received a 0.6, or 60 percent. Translated to a 12-point scale, the score was 7.2—60 percent of 12. This score was then combined with a similarly calculated score for physician organizations that reflected their participation in quality improvement collaboratives. Component scores within a given attribute were rolled up into an overall score for the category.

CHI and RWJF staff also interviewed 15 or more key informants within each community and made two-day visits to each region to conduct one-on-one and group meetings with key community stakeholders.

By synthesizing the quantitative and qualitative data, the study identified regional strengths and opportunities. As seen in the following tables, the vast majority of markets scored a C in the overall Matrix, suggesting that most communities’ health care markets do not yet have strong foundations for improving health care quality. Specifically, 12 of the 14 communities scored a C, or “basic,” on the Matrix. Boston alone scored a B, with 43.2 points of a possible 84, while Oklahoma City ranked lowest, with a score of D, or 20.1 points.

What marks the differences between the “highest” and “lowest” scoring communities? Boston had strong, B-level performance measurement in place and solid B scores in community leadership, public reporting and health information technology. Oklahoma City, by contrast, had strong community leadership, but almost no incentives or infrastructure for health information technology, only minimal consumer engagement, and few physician financial incentives. Unlike Boston, Oklahoma City had minimal multi-stakeholder efforts in which different market interests work together to improve care. However, even as the lowest overall scorer, Oklahoma City still outranked Boston in its collaborative provider quality improvement efforts, which demonstrates how significantly communities varied in their scores for individual attributes.

It remains to be seen which of these seven attributes might have the greatest impact on a community’s quality of care. It is possible that two identically scored communities may ultimately have very different quality outcomes, depending on the impact of each attribute. For example, one community may choose to invest its resources in health information technology and incentives, while another chooses to publish report cards and link physician payments to the results of those reports. While the two communities may have identical composite scores on the Matrix, it is unknown which of their respective investments might actually produce higher-quality care.

Looking at the average individual attribute scores, there is clearly room for improvement in every area. Across the board, communities scored best (B) in community leadership and

Table 1 Market Readiness Matrix Communities in Alphabetical Order

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

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

performance measurement, followed by public reporting (level C). On all other attributes, communities scored Ds. Overall, average attribute scores are as follows: Community Leadership, 7.5 (B); Performance Measurement, 7.3 (B); Public Reporting, 5.8 (C); Quality Improvement, 2.8 (D); Physician Financial Incentives, 2.4 (D); Consumer Engagement, 2.1 (D); Health Information Technology Incentives and Infrastructure, 1.5 (D).

Key Policy Implications of the Study

- *There are multiple opportunities for intervention at the local level.* For instance, communities need help improving their performance measurement regarding quality and price, as well as public reporting of those measures. Similarly, almost all communities need help developing practical approaches to engage consumers in health care quality issues.
- *All health care is local or, at least, regional.* This market scan sheds new light on just how different communities are in their health care delivery, leadership and infrastructure. Ultimately, these differences shape and inform the single most critical driver of health care decisions—the individual’s experience receiving health care from her doctor.
- *The interplay, relationship and evolution of market attributes deserve additional study.* These seven key market readiness attributes may not necessarily correlate directly with improved health care quality or value. Further, they may not all contribute equally to a given market’s success. There also may be additional important attributes that the study does not examine.
- *The public sector has a critical role to play.* The market scans uncovered many examples of public-private partnerships to advance quality. Federal support at the local level includes the leadership of federally contracted quality improvement organizations, the Agency for Healthcare Research and Quality providing assistance to local HIT efforts, multiple regional demonstration projects by the Centers for Medicare & Medicaid Services, and the Department of Health and Human Services’ transparency initiatives.⁴ At the state level, many state employee purchasing programs and a few Medicaid programs are working with private-sector counterparts to adopt value-based buying strategies. As federal, state and local entities continue to invest at the local level, it will be critical for public and private efforts to work in concert to learn more about the important market dynamics that affect quality improvement and to maximize the effectiveness of efforts to help communities develop well-functioning health care markets.

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To view the full report, please visit www.rwjf.org/qualitypubs or www.forces4quality.org.

NOTES

¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the Twenty-first Century*. Washington: National Academy Press, 2001.

² Health care value here means quality of patient outcomes relative to cost of care necessary to achieve those outcomes.

³ Because there is no definitive source on physician organizations, health plan key informants and other community-specific resources were used to identify the top 12 that have at least six affiliated nonspecialist physicians. The physician organizations and federally qualified health centers served as indicators of whether collaborative quality improvement programs for four high-cost/high-volume chronic conditions and prevention were taking place in the community. The Institute for Healthcare Improvement and regional coordinators for the Bureau of Primary Health Care Health Disparities Collaboratives generously provided information for these criteria.

⁴ See Department of Health and Human Services Value Driven Health Care Web site: www.hhs.gov/transparency.