GRANTMAKERS IN HEALTH

Improving Quality:

Long-Term Vision and Incremental Change

Quality is one of the most pressing issues facing the health care system today. More than $2 trillion is spent on health care each year in the United States (AHRQ 2009). But, are we getting the best care?

In 2000 the Institute of Medicine (IOM) Committee on Quality on Health Care in America astounded the nation with its estimate that up to 98,000 patients die each year in U.S. hospitals because of medical errors – more than from car accidents, breast cancer, or AIDS (IOM 2000). The committee concluded that poor quality is the result of bad systems, not bad people. To fix the problem, the focus should be on redesigning these systems, not changing individual behavior.

While there is general agreement about what our health care system needs in order to work more effectively and efficiently, there is no one solution to quality improvement. Instead, a long-term, multifaceted approach is required (IOM 2001). Quality improvement necessitates collaboration between and among health care organizations, providers, patients, policymakers, and others.

Progress, however, has been slow. According to the federal Agency for Healthcare Research and Quality, a substantial gap exists between the best possible care and the care people receive. For example, the agency's 2008 *National Health Quality Report* found that across the care measures tracked, patients receive recommended care less than 60 percent of the time.

FOUNDATIONS WORKING TO IMPROVE QUALITY

Improving delivery system efficiencies, reducing medical errors, putting best practices to work, and adopting a more patient-centered approach to care all contribute to higher quality. Creating sustainable changes in how our health care system functions and the way medicine is practiced, however, is extremely complex. It requires a long-term vision and commitment coupled with a tolerance for incremental change.

Foundations use a variety of approaches to support quality improvement efforts at the local, state, and national levels. Over the last two decades, foundations such as the California HealthCare Foundation, The Commonwealth Fund, the Jewish Healthcare Foundation, and the Robert Wood Johnson Foundation have been at the forefront of quality improvement. They have supported work to translate research into practice, develop quality measures, build the business case for quality, and establish regional quality collaboratives. In doing so, they have challenged the status quo. Their willingness to act as agents of change and their long-term commitment to this work have begun to drive quality improvement in a variety of settings.

Building on this rich history, other foundations have begun to support work creating a more patient-centered system of care and bringing consumer voices to the issue of health system reform. This work requires significant investments of money, time, and staff resources. Through it, foundations have turned a cacophony of consumer voices into coherent, actionable work and have created tools that provide meaningful information to consumers.

➤ ***Developing a Patient-Centered Care Approach*** – In April 2008 The Commonwealth Fund launched a five-year demonstration and evaluation of the patient-centered medical home (PCMH) model of primary care delivery. In PCMH practices, patients receive coordinated services and enhanced access to a team of providers. Clinicians also use decision support tools, measure their performance, engage patients in their own care, and conduct quality improvement activities. The initiative is designed to improve the quality of care and patient experience, as well as to reduce health system costs (The Commonwealth Fund 2010).

The PCMH initiative was launched in 68 safety net primary care clinics in five regions, including Colorado, Idaho, Massachusetts, Oregon, and Philadelphia. Five Regional Coordinating Centers were selected to participate in the demonstration project. Each center partnered with 12 to 15 safety net clinics in their state. The collaboratives receive technical assistance on practice redesign topics such as care coordination, enhanced access, and patient experience. They also receive funding to support a medical home facilitator to lead quality improvement projects and other activities (Qualis Healthcare 2010). PCMH projects in each region are also supported by local foundations such as The Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, Blue Cross Blue Shield of Massachusetts Foundation, and The Boston Foundation.

A team of researchers from the University of Chicago received a grant from The Commonwealth Fund to evaluate the project. The team will determine whether or not participating clinics become medical homes, how medical homes affect quality and efficiency, and the factors that are associated with a clinic's successful implementation of the PCMH model (The Commonwealth Fund 2010).

➤ ***Finding Time to Talk to Patients*** – For consumers, patient care means having providers show respect for patients as individuals, taking the time to listen, and conveying complex information in understandable ways. One unique approach is the shared medical appointment (SMA). Begun in 1991 at a Kaiser Permanente clinic in Colorado, the Cooperative Health Care Clinic Model (CHCCM) was designed as an outpatient program to improve the quality of care provided to non-frail older patients with multiple chronic conditions. Several models exist, but the common feature is bringing the same group of patients together with the same physician and/or nurse at regular intervals. A two-year study of the CHCCM, funded by the Robert Wood Johnson Foundation, found high rates of patient satisfaction among SMA participants, as well as fewer hospital admissions and emergency room visits (Scott et al. 2004).

Salud Family Health Centers, a grantee of The Colorado Health Foundation, began using SMAs to accommodate its growing number of patients. Using this model, they are able to leverage the time a provider spends with patients, as well as the amount of information imparted during each visit (The Colorado Health Foundation 2008). Salud generally uses group appointments for diabetic patients and pregnant women. They average six patients and run for 90 minutes.

SMAs are not widely used. In fact, less then 1 percent of physicians participate in group appointments. However, the growing demand for health services may change that. As Dr. John Scott, who originated the CHCCM, points out, "At first, all the doctors were hostile. They said it would destroy the doctor-patient relationship when, in fact, it enhances it" (The Colorado Health Foundation 2008).

➤ ***Bringing Consumer Voices to the Reform Debate*** – In early 2009 Reaching for Excellence traveled throughout western New York listening to consumers, community groups, health and social service providers, advocates, employers, and others to find out what people wanted for the future of health care in their region. The $1-million effort, supported by the Community Health Foundation of Western and Central New York (CHFWCNY) and the John R. Oishei Foundation, was prompted by statewide efforts to improve quality and access within the health care delivery system. Specifically, the state called for hospital consolidations and closures in the region as part of a multipronged approach to reconfigure New York's health care resources. This strategy, however, lacked the perspective of the people using the health care system (Davis 2009).

In 2007 CHFWCNY and the Oishei Foundation partnered with the P^2 Collaborative of Western New York and the University at Buffalo's Regional Institute to find out what residents wanted and how the system could be improved. Reaching for Excellence emerged as the first comprehensive review of western New Yorkers' perspectives on health care (Davis 2009). The cornerstone of the work was a series of community conversations. Generating meaningful discussions for both community members and Reaching for Excellence partners was a significant challenge. As Ann Monroe (2009) president of CHFWCNY explains, "We didn't know how to do it and were afraid that people would just come and complain." She added that the partners "needed to find language and a way of talking about complex [health care delivery system] issues that people could understand."

"One Friday: Four Futures," as the conversations were called, emerged through a scenario planning process that engaged more than 30 key health and community leaders. The centerpiece conversations were four stories portraying distinct health care futures. In late 2008 Reaching for Excellence took its stories on the road. More than 1,700 people took part in 114 gatherings in eight counties. During the discussions, residents were asked questions such as "What should the system be delivering for you?" and "How do you want to be treated?" The project team engaged a broad cross-section of the region's population purposefully going to communities facing serious health care challenges (Reaching for Excellence 2009a).

Five key health care priorities emerged from the community conversations. Western New Yorkers said they wanted

- care that is compassionate, respectful, and understanding of patients' needs;
- timely and efficient care;
- understandable information to help them make better and more proactive choices about their health;
- a system that embraces preventive care; and
- broader access to care for all populations (Reaching for Excellence 2009b).

Results from the community conversations led Reaching for Excellence partners to create a set of priorities and goals for western New York health care. The team has also begun to lay groundwork for quality improvement efforts in hospitals, health centers, and doctors' offices throughout the region. Future efforts include development of measureable indicators of success and consumer report cards.

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