Multi-Stakeholder Alliance Contributions to the Spread of Health Care Quality Improvement Programs

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Background

Despite considerable attention devoted to quality improvement (QI) over the past 40 years and the widespread adoption of QI practices among health care providers, evidence continues to show shortcomings in the quality of health care delivery.\(^1\)\(^-\)\(^3\) Many researchers and policymakers maintain that in order to achieve meaningful and sustainable improvement, quality efforts need to advance from organizational-level initiatives to broader, community-wide efforts that collectively engage providers, payers, purchasers, and consumers.\(^4\)\(^-\)\(^6\) Community-wide QI efforts may be more effective than individual approaches if they can eliminate duplication of efforts, improve information sharing across settings, and influence key factors that are out of the control of individual providers (e.g., payment reforms).\(^6\)\(^-\)\(^8\)

In an effort to test this theory, sponsors in the public and private sectors have established programs that offer technical assistance and/or funding to multi-stakeholder (payers, providers, purchasers, and consumers) alliances committed to improving quality at the community level. Examples include the Agency for Healthcare Research and Quality’s Chartered Value Exchange (CVE) program, the Office of the National Coordinator’s Beacon Program, and the Robert Wood Johnson Foundation’s Aligning Forces for Quality (AF4Q) initiative.

Purpose

The AF4Q evaluation is measuring the effectiveness of community-level QI interventions by examining the development of the alliances’ QI programs and infrastructure, assessing the extent to which interventions are implemented, and linking these efforts to intended quality outcomes.\(^9\) In this study, our goal was to examine whether and how 16 multi-stakeholder alliances participating in the AF4Q program approached the task of spreading QI programs within their communities. In this research summary, we report on alliance roles and strategies to spread QI activities, offer specific examples of the magnitude of spread over time, and describe lessons learned based on the AF4Q experience. Information was drawn from interviews with alliances’ QI leaders conducted by the AF4Q Evaluation team in Spring 2013.
AF4Q Alliance Roles in the Spread of QI

RWJF created AF4Q under the premise that “no single person, group or profession can improve health and healthcare throughout a community without the support of others.” Under AF4Q, multi-stakeholder alliances were charged with spreading promising QI activities within their communities. We define spread as expanding the number of program participants over time.

While guided by technical assistance and AF4Q program-specific goals and measures, alliances had considerable latitude regarding how to spread QI within their communities. We found varying levels of involvement in the spread of QI activities by alliances. Among the 16 alliances, 5 took an active, “boots on the ground” approach to spreading QI activities in their communities. For alliances who took this active role, QI spread was often considered a central component of their day-to-day work.

Another six alliances delegated the spread task to partner organizations. Delegation was a typical approach for alliances whose more experienced partners were better positioned to stimulate QI spread. One example of this was found in Minnesota where the alliance partners had considerable experience implementing QI initiatives. The AF4Q grant holder, Minnesota Community Measurement, was a new organization with no experience initiating or leading QI activities, and therefore coordinated with the Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association, and the state Quality Improvement Organization, Stratis Health, to lead and spread AF4Q-related QI work.

Finally, it took several years for most alliances and/or their partners to develop AF4Q-related QI activities. As a result, five alliances did not have a QI activity that was fully implemented and ready to spread at the time our interviews were conducted in early 2013. For example, the Greater Boston Quality Coalition joined AF4Q in 2010 and took a very active role in establishing its own QI activities. One of the alliance’s main QI projects began in 2012 and involved working with physician groups to reduce unnecessary emergency department visits and admissions for asthma and diabetes. According to alliance members, the effectiveness of this project had not yet been demonstrated and the alliance was not yet focused on spread. However, one alliance member stated, “We have structured [our work] in such a way that we hope we’ll be able to replicate what we’re doing in other neighborhoods and communities.”

Strategies Used to Spread QI Activities

Learning networks: A number of communities established learning networks where local hospitals and physician practices gathered (virtually or in person) to discuss QI in a non-competitive environment. One example is Better Health Greater Cleveland’s Quality Improvement Learning Collaborative, which brings together local providers for biannual summits during which high performing practices in the community are invited to discuss their QI strategies.

Practice coaching: Several communities launched initiatives that employed “practice facilitators” or “QI consultants” to provide ongoing mentoring to practices. For example, the P2 Collaborative of Western New York hired 16 full-time Practice Enhancement Associates to work directly with physician practices to improve diabetes care and help practices use electronic health records. Other alliances offered practice coaching to spread implementation of patient-centered medical homes (PCMHs).

New partnerships: Several alliance leaders said that they spent considerable time recruiting new participants into their QI activities. One alliance member pointed out the importance of “capturing the right representation” in a community, stating that, “It’s not necessarily the hospitals or the health plans; it could be community coalitions or faith based organizations.” Maine Quality Counts, for example, successfully expanded its Health Homes program by reaching out to the state and convincing Medicaid officials to adopt the alliance’s Health Homes program rather than initiating their own.

Toolkits and resources: The P2 Collaborative of Western New York partnered with local organizations to develop the Ambulatory Quality Improvement Regional Center (AQIRC) to facilitate the spread of QI resources and information. AQIRC was created to provide training and on-site consultation to practices in chronic care management, QI concepts and tools, practice design, and health information technology (HIT) support.
### Examples of QI Activity Expansion

Although the type of QI activities, timeframe of spread, and unit of participation (e.g., hospitals, health plans, practices) varied across the alliances, the majority of AF4Q alliances were involved in successfully expanding participation in at least one QI activity. While we do not provide an entire list of all QI efforts, the examples provided in the table below help to demonstrate the magnitude of the spread achieved (i.e., increase in the number of participants over time).

<table>
<thead>
<tr>
<th>Community</th>
<th>Example QI Initiative</th>
<th>Number of Participants at Program Start</th>
<th>Number of Participants at Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cincinnati</td>
<td>Patient Centered Medical Home (PCMH) Initiatives: The Health Collaborative created this project to encourage community-wide adoption of the PCMH model. The PCMH work was extended through the Beacon grant with a focus on care coordination. The alliance facilitated spread by serving as a convener, reaching out to the community, and having ongoing discussions with payers, participants, and employers. Then local health systems took the PCMH pilot work, creating a “rapid–fire” version of the pilot. Cohorts of seven practices attended weekly learning sessions, compared with quarterly learning sessions in the pilot phase, allowing a quicker adoption of PCMH certification requirements.</td>
<td>4 practices (2009)</td>
<td>Over 100 practices (2013*)</td>
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<td>Cleveland</td>
<td>Learning Collaborative: Modeled after the Institute for Healthcare Improvement’s Breakthrough Series Collaborative and the Chronic Care Model, Better Health Greater Cleveland launched this effort to provide physicians with timely performance feedback, set data-driven goals, and train in QI methods. Information on QI interventions and best practices is spread through this collaborative setting.</td>
<td>Providers from the Cleveland VA health system (2006)</td>
<td>Over 200 clinicians and staff members, primarily from the VA, Kaiser, MetroHealth, and the Cleveland Clinic (2014)</td>
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<td>Detroit</td>
<td>Primary Care Physician (PCP) Access Pilot: The Greater Detroit Area Health Council partnered with Blue Cross Network and a local physician organization to reduce emergency department use for primary care treatable conditions. The PCP access pilot was spread through development of an online toolkit and multiple presentations in the community.</td>
<td>12 physician practices in 1 physician organization (2007)</td>
<td>2 physician organizations (2014)</td>
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<td>Humboldt</td>
<td>Priority Care: The Humboldt Del-Norte Independent Practice Association (IPA) implemented a care management project to reduce the total cost and services for high risk and complex patients. This project works to redesign the care process and contracts with health plans and self-insured employers to provide IPA nurses to assist with the care management. The project also focuses on improving access to ambulatory care services, hospital discharges, and chronic disease management. The initiative spreads through demonstrating the benefits of participation to additional employer purchasers.</td>
<td>300 patients (2010)</td>
<td>Over 1,000 patients (2014)</td>
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<td>Maine</td>
<td>The Quality Counts Learning Community: Maine Quality Counts offers a range of monthly educational webinars highlighting best practices and QI approaches for ambulatory providers and practice staff, as well as an annual conference. Spread is promoted through adding new content to match the interests of new participants.</td>
<td>10 participants, including providers, administrators, patients, and consumers (2008)</td>
<td>Over 1,000 total participants; averages 50-100 participants per session (2014)</td>
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<td>Minnesota</td>
<td><strong>Reducing Avoidable Readmissions Effectively (RARE)</strong>: The Institute for Clinical Systems Improvement (ICSI), Minnesota Hospital Association (MHA), and Stratis Health partnered to reduce avoidable hospital readmissions. RARE focuses on comprehensive discharge planning, medication management, family and patient engagement, care transitions, improved communication during transitions, and practice coaches. Aligning program goals with financial incentives for reimbursement facilitated spread.</td>
<td>77 hospitals (2012)</td>
<td>82 hospitals (2013*)</td>
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<td>South Central PA</td>
<td><strong>Payment Reform Involving Corporate Engagement (PRICE) project</strong>: The AF4Q South Central PA PRICE council coordinates improvement work at the regional level for PCMH, bundled payment, and new areas of payment reform. The alliance encourages new participants and engages key leadership to facilitate spread.</td>
<td>1 health plan and 1 medical group (2011)</td>
<td>8 health plans, 8 medical groups and 4 employers (2014)</td>
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<td>West Michigan</td>
<td><strong>The COMPASS Consortium</strong>: The Michigan Center for Clinical Systems Improvement is part of a national consortium of organizations spreading the use of collaborative care management in communities. Key components of this model are the use of care managers and consultation by physicians with specialized training in targeted diseases (depression and co-morbidities of diabetes, coronary artery disease, or cardiovascular disease), intended to improve care through effective coordination with other disciplines (beyond primary care). Spread is facilitated through disseminating information to the front line staff in newsletters, and providing training sessions to share the evidence-based elements and best practices.</td>
<td>12 primary care practices (2012)</td>
<td>19 primary care practices (2014)</td>
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<td>Western New York</td>
<td><strong>Health Information Technology (HIT) Initiative</strong>: The Office for the National Coordinator for HIT funded Regional Extension Centers (RECs) across the country to assist healthcare providers with implementation and use of electronic health records by providing training, support, and technical assistance. The <strong>P² Collaborative of Western New York serves as an extension agent facilitating spread through practice coaches and hosting collaborative learning sessions to diffuse information.</strong></td>
<td>500 providers (2010)</td>
<td>861 providers (2013)</td>
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<td>Wisconsin</td>
<td><strong>Transforming Care at the Bedside (TCAB)</strong>: The Robert Wood Johnson Foundation and the Institute for Healthcare Improvement developed the TCAB learning collaborative to improve the delivery of care in hospital medical and surgical units. The Wisconsin Collaborative of Healthcare Quality promoted spread by connecting with nurse leaders to better understand their challenges and to promote areas where nurses can learn from one another. The alliance also used the first cohort of participants as leaders in the second and subsequent cohorts.</td>
<td>15 hospitals (2011)</td>
<td>36 hospitals (2014)</td>
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<td>Washington</td>
<td><strong>Qualis Health Regional Extension Center (REC)</strong>: Qualis Health, the local Quality Improvement Organization leads the REC work in Washington. The REC assists medical groups that are working towards electronic medical record adoption and meaningful use. Spread is facilitated through practice coaches, webinars, and reaching out to practices regarding the benefits of participation. The Washington Health Alliance collaborates with the REC and other partners to align the shared learning opportunities between QI and meaningful use.</td>
<td>Unknown (2010)</td>
<td>Over 900 practices (2014)</td>
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*Program End Date*
Challenges

In interviews, alliance members identified the following challenges or barriers, which limited their ability to effectively spread QI activities.

- Alliance members reported that spreading QI activities was labor intensive and some alliances lacked the capacity and resources to expand their QI work.
- Members of The Health Collaborative in Cincinnati noted that payment reforms have not advanced enough to encourage long-term investment in QI, and as a result, physicians question whether changes will ever “pay off.”
- Many QI efforts are “invisible” to patients, and patients are not pushing their providers to engage in QI activities.
- Turnover in leadership at the participating organizations, especially related to the TCAB hospital initiative, hindered the alliances’ work.
- It was difficult to get physicians to focus on QI. A member of the Greater Detroit Area Health Council discussed receiving the following pushback from physicians: “I’ve already got so much on my plate. I don’t need another initiative; we’ve already addressed that; you don’t know our doctors, they won’t do this; it’s all the patients’ fault – the employers need to change the economic structure and quadruple the emergency room co-pays.”
- It was challenging to work with smaller, independent practices because the partners don’t have the time or resources to focus on QI. However, it was challenging to spread QI to larger practices because of the office bureaucracy, and the fact that the health systems, not the physicians, controlled the finances and resources.

Lessons Learned

Collectively AF4Q alliances were able to expand the number of QI program participants over time. Based on their experiences spreading QI activities, AF4Q alliance members identified several factors that may facilitate the spread of future QI efforts.

**Aligning QI activities with the goals of participants:** Alliances found spread was expedited when the goals of the QI initiative aligned with the goals of participating organizations. For example, several alliance members noted that the Affordable Care Act’s emphasis on reduced costs and reduced readmissions helped align goals and resulted in an increased demand for QI. Additionally, members of the P² Collaborative of Western New York and the Washington Health Alliance reported that physician practices were enthusiastic about the alliances’ electronic health records work because of the federal meaningful use regulations. Further, alliance members stated that aligning payment reform incentives with QI activities helps to facilitate participation.

**Establishing trust:** In several communities, overcoming the competitive culture or lack of historical collaboration was challenging, and QI leaders said it was essential for the alliance to be viewed as a respected, trusted resource in the community. One alliance leader remarked, “I think you really need to establish yourself as a convener of sorts and have that trust level there and the key players there.” Furthermore, alliance members frequently mentioned the importance of engaging all stakeholders in the process; one stated, “I think bringing together the stakeholders to partner, and everybody taking a role and being clear about what that role is, and routinely meeting and having open communication is really key.” Several other alliances found that obtaining employers’ participation was often overlooked but essential. Because many large employers are self-insured, they are therefore motivated to find high-quality healthcare services to keep the workforce healthy and reduce costs.
Lessons Learned Continued

**Pursuing grant support:** Alliance members reported receiving grant support that facilitated spreading QI activities. For example, grants from the Office of the National Coordinator and the Centers for Medicare and Medicaid Innovation were instrumental in expanding the capacity of the $P^2$ Collaborative of Western New York to recruit new partners. Local foundations also supported spread work in Cincinnati.

**Showing evidence of success:** Alliances found that the successes of early adopters helped with recruitment of new participants. Several alliances noted that the excitement and enthusiasm regarding the successes of pilot initiatives was a key factor in spread. One alliance member stated:

“The preliminary success of that program was so evident that we began talking with other employer groups about incorporating this [care management] program into their benefits structure. They were looking for ways to improve quality and reduce healthcare expenses...”

**Recognizing leadership as a facilitator:** Numerous alliances found that having top leadership involved was key to sustaining and spreading initiatives. According to one alliance member, “If you don’t have the top as far up, as high, and I would say CEO or Senior VP level of these systems....., it’s not going to work. They have to see the value.” Even after achieving top-level leadership support, alliances saw turnover as a barrier to spread. Leadership turnover can lead to loss of buy-in and momentum. In New Mexico, this was mitigated by involving multiple levels of leadership, specifically the unit managers in addition to the chief nursing officer to create a more shared level of commitment.

**Setting Realistic Goals:** Alliances found that selecting reasonably sized goals and interventions facilitated spread within the community. The Washington Health Alliance found that focusing on a smaller number of goals and providing partners with the time and resources to achieve the goals was more effective than having a broad QI agenda. According to one alliance member, this scaled back approach is more effective because providers are already “pretty overwhelmed” by the number of QI initiatives and requirements, and a simpler approach is more likely to receive attention from the practices.

Conclusions

- Due to their collaborative nature and role as serving as a neutral convener for the community, multi-stakeholder alliances are well suited to facilitate the spread of QI interventions and best practices across communities.

- Some alliances led the spread of QI and others delegated to a partner organization. Across the AF4Q alliances, both strategies resulted in expanding the number of participants involved in QI activities.

- Obtaining additional grant funding facilitated the spread of QI initiatives.

- The most common approaches to spreading QI was through the use of practice coaches and learning collaboratives. Practice coaching permits tailored, individual consultation whereas learning collaboratives can spread information across a large number of providers relatively quickly.

- Valuable technical assistance and incentives that help to engage physicians, promote QI work, and align goals also helped alliances overcome barriers to spread.

- Several alliances were able to identify and adopt interventions that had been developed through national programs or in other AF4Q communities. This diffusion across communities assists alliances by providing a framework for improvement that has been tested and can be quickly adapted to meet the needs and context of each community.
The Aligning Forces for Quality (AF4Q) is a 10-year initiative of the Robert Wood Johnson Foundation to improve health care, reduce disparities, and create national models for health reform. The initiative provides funding and technical assistance to 16 multi-stakeholder alliances across the U.S. to implement a variety of health care interventions, including efforts to improve quality in health care delivery at the community level.

This research summary was produced as part of the the AF4Q Evaluation, also funded by the Robert Wood Johnson Foundation, to measure the impact of the AF4Q initiative and describe key lessons learned.

For more information about the AF4Q initiative visit aligningforces.org

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