

It Takes a Region: Lessons from a National Conference on Better Ideas for Chronic Disease Care

Regional Approaches to a National Problem

Regional coalitions of multiple stakeholder groups are at the leading edge of health care quality improvement (QI) efforts around the United States. Providers, purchasers, plans, consumers, state and local governments, and other stakeholders are joining forces and devising systematic ways to transform health care in their regions.

In the absence of a national strategy to organize care and promote innovation, these activities offer the best hope for change. The nature of the health care crisis is well documented: more than 98,000 unnecessary hospital deaths a year; half of all treatment for those with chronic conditions is not based on clinical guidelines; primary care providers closing their practices, unable to make a living; and most Americans express dissatisfaction with their health care. Such challenges are likely to become even more acute as the U.S. population ages and the incidence of chronic illness increases.

The last decade has seen an increase in the number and impact of regional QI initiatives, which have formed spontaneously or in response to funded initiatives to address the escalating cost and mediocre quality of health care. The size of the targeted regions range from cities to large rural areas to entire states. Those watching this phenomenon have recognized the potential

national significance of the initiatives as agents and models of health care reform and the possibility of strengthening them through shared learning and networking.

In a recent California HealthCare Foundation (CHCF) report, *It Takes a Region: Creating a Framework to Improve Chronic Disease Care*,¹ authors Ed Wagner, M.D., and colleagues from the MacColl Institute of Healthcare Innovation look at regional quality improvement activities through a national lens and describe the key commonalities. Although varied local conditions have generated a range of approaches, the strategies fall into several large categories, outlined briefly here and in greater detail in *It Takes a Region*. The authors state that successful programs use several strategies simultaneously, as illustrated in Figure 1. They stress the importance of achieving population-level results. And they encourage regional leaders to share experiences and learn from each other to augment the limited evidence available to guide their efforts.

National Networking Conference, November 2006

The MacColl Institute and CHCF gave the networking process a major boost by convening a national conference near San Francisco in November 2006. About 80 leaders of 40 organizations in 17 states (see Appendix) spent a day and a half together, sharing lessons learned and challenges and exploring ways to strengthen

Figure 1: Framework for Creating a Regional Health Care System



their individual and collective efforts. The conference helped crystallize a national perspective on quality improvement, grounded in the practical experience of these diverse participants. Their organizations, which range in age from more than 50 years to less than 1 year, are spread from coast to coast. Both the differences and the similarities among them were instructive and highlighted not only possible new partners and ways to approach local challenges but also reassuring commonalities among their experiences.

The conference generated these key findings:

- **On origins:** Cost and quality concerns are the major spurs for action and coalition-building, bringing diverse stakeholders and even competitors together to establish new forms of communication and accountability and change the way health care is provided and financed.
- **On scope:** To be effective, coalitions must include a broad range of partners, including payers,

providers, plans, and the public. In most regions, national health plans are an essential partner that is still missing from the coalition table.

- **On reach and impact:** Quality improvement efforts must strive to benefit all members of the population, not just some, and they need to engage all health care practices to accomplish this goal. This is a major challenge because the small primary care practices that are prevalent in most areas are struggling for survival.
- **On payment issues:** Regions are limited in their ability to remedy basic payment system irrationalities and nationwide reform of health care financing is urgently needed.
- **On staying power:** Even well-established coalitions have concerns about sustainability and need viable business models. To solidify community support, coalitions need to measure and show their impact on health care quality and community health. They also can demonstrate their value by tackling tough local issues such as the distribution of costs and benefits.
- **On potential new partners:** State government, especially Medicaid, can be a valuable partner in many areas. In addition, there are synergies between regional quality improvement initiatives and the federal agenda.
- **On future networking:** Coalitions have much to learn from each other. It is important for them to find ongoing ways to network so they can share successes and make positive change more visible.

Key Ingredients

Learning from the Large Systems

As explained in *It Takes a Region*, large health systems such as the Veterans Administration or Kaiser are making the most demonstrable strides in improving patients' health outcomes. This is not surprising: Integrated organizations that are responsible for both

care delivery and financing can coordinate care and align payment to reinforce delivery system changes that improve care. And centralized, globally budgeted organizations will reap the financial benefits from such ambitious changes over time. These options and benefits are far less available to isolated, overwhelmed practices coping with a fragmented delivery system.

The communities at the leading edge of quality improvement have been able to overcome some aspects of fragmentation by joining forces to create health care “systems” that can behave in a more coordinated and comprehensive fashion. This enables them to set common goals, share performance data, connect and support providers, engage consumers, and in other ways promote better health care quality and community health outcomes.

A Compelling Mission

Initiatives of this kind do not come about without a clear and compelling mission and strong leadership, often from local business leaders. The impetus usually involves some combination of worrisome community health and mounting health care costs, perhaps galvanized by a funding opportunity. The programs represented at the conference provided examples of a variety of organizational missions, such as improving diabetes care and outcomes in a region, or reducing health care costs in an urban area by \$500 million over three years.

Participation by Diverse Stakeholders

Community-wide quality improvement requires collaboration across a broad range of public and private stakeholders. The key players are from the payment, provider, purchaser, and general public arenas. Participants noted the particular wisdom of involving competitors and those who could be negatively affected by decisions. Public health, elected officials, or members of the business community often serve as trusted conveners who provide a neutral

table around which stakeholders can gather. The variety of constituencies represented in the conferees' membership lists stimulated new thinking about partners that might be brought into the mix.

Strong, Multifaceted Leadership

The group examined features of the strong leadership needed to convene stakeholders, help them agree on a mission and strategies, and mobilize needed resources. Participants highlighted the varied potential sources of leadership, including ones outside the health care system, and the importance of leadership at all levels, including staff and board members. It was noted that early on, leadership's role is to "pull" coalition members into a shared vision; later, success depends on leadership's ability to "push" the collaborative partners to commit to ambitious objectives.

Trust was a central theme of the conference discussions and there was common agreement that nurturing trust is a vital commitment and task of leadership and one in need of constant attention. The ongoing work to sustain trust among stakeholders with diverse interests is a major reason coalitions are in a unique position to bring about real change in American health care.

At the same time, several people stressed that trust coexists with tension among stakeholders, and coalitions must reach a comfort level with that tension. Indeed, such tensions are necessary to create the energy to force decisive action and positive change.

Strategies for Regional Quality Improvement

It Takes a Region provides a useful conceptual structure for the presentations and discussions. This theoretical template made it possible to explore common issues and lessons in the participants' experiences and to recognize the growth opportunities represented by the differences among them. As noted,

the framework in Figure 1 brings together the four key activities of regional quality initiatives.

Share Data for Performance Measurement

Quality improvement efforts use performance data for two chief purposes: providing health care practitioners with mechanisms to motivate and inform improvements in care, and providing consumers and purchasers with objective information to guide choice and support accountability. In addition, health information exchange (HIE) enables providers to share patient-level data and coordinate the care of patients for whom they share responsibility.

Several stakeholder groups—in particular, payers, purchasers, and consumers—want performance data, and collecting and reporting this information is a major activity of regional coalitions and often the reason for their creation. Other stakeholder groups, such as providers, are primarily focused on data for improvement. The participants had a good deal to say about the work and collaboration needed to establish measures and acquire, aggregate and report performance data. The process involves integrating claims (insurance billing) data across payers, including Medicaid and Medicare, along with clinical data wherever possible. A major focus of the discussion was the political work involved in building and maintaining trust among coalition partners around such questions as who collects and "owns" the data and how performance measures should be designed and reported. To maximize trust among providers and the public, the clinical improvement and public reporting uses of the data should be kept separate.

Theoretically, health information technology (HIT) can facilitate all these functions. In reality, though, the focus has been on collection of data for reporting and, to a lesser degree, for improvement. Efforts to exchange clinical data between providers (HIE) are evolving very separately from these other functions.

The conferees discussed possible remedies for this lack of alignment, such as connecting regional health information organizations, or RHIOs, to regional QI and reporting initiatives.

Engage Consumers

As health care recipients and partners, consumers should be key participants in regional QI coalitions, even though they are likely to be the last ones to the table. The importance of engaging them, and ideas and questions about how to do so, were themes that threaded through the conference discussions. Several local approaches were described, such as consumer seats on advisory boards, educational services, and incentives that reward good personal health practices with lower insurance rates.

The bulk of consumer-oriented experience to date, however, is with public reporting of performance data; and so far that has not been shown to have much effect on consumer behavior. The most important take-home message regarding this group was that more research and experimentation are needed to understand what people want with respect to quality and how best to communicate with them.

The discussions generated the important insight that people need different kinds of information and support in their roles as consumers—when they are researching and choosing a provider for themselves or a family member—and as patients—when they are receiving medical care and making treatment decisions with their providers. In both cases, an underlying principle is that people want help to manage their health and be effective partners with their health care providers. To date, most coalitions have focused on the public's role as consumers. There was recognition that supplying information to help people be better-informed patients held promise.

Improve Health Care Delivery

Motivating and helping providers redesign their care systems to provide more cost-effective care is a core activity of quality improvement efforts. The discussions and presentations on this topic highlighted methods such as practice networks, skill-based learning, clinical guidelines, and information technology that many coalitions are using to help providers improve care. In addition to these skill-building activities, the conferees explored important “will” factors such as trust and the key roles of established social networks and peer leadership. They also discussed ways to restructure primary care, such as team care and more efficient deployment of physicians' time.

It became clear early in the November 2006 meeting that while necessary, all such approaches to strengthening providers' will and skill are insufficient without parallel work on fundamental system reform. The payment system irrationalities that bedevil primary care are obstacles largely beyond local control. Simply put, with existing reimbursement structures, the better quality physicians provide, the worse their reimbursement. Some suggested that if reimbursement stopped penalizing, or even started rewarding, high quality care, physicians' normal desire for good outcomes would prevail and the interventions known to be effective in supporting that effort could come into play. Participants expressed interest in North Carolina and Indiana programs that combine increased community-based infrastructure for individual practices with other care delivery improvements, supported by Medicaid.

All regions face challenges in engaging the small, isolated practices that typically lack the time and resources to share learning, strengthen infrastructure, and make needed changes; and such practices predominate in many parts of the United States. Nevertheless, a strong message of the conference was that regional coalitions must redouble their efforts to

involve all providers in quality improvement, because that is the only way to achieve population-scale results. Some stressed the importance of supporting, in particular, those who are working with the disadvantaged and underserved.

Align Financial Incentives and Payment Structures

As noted, payment system irrationalities and inequities were a dominant and cross-cutting conference theme. Having discussed this problem in other contexts, the conferees focused in their finance and payment session on the inadequacies of Pay for Performance schemes as a remedy. Some federal and private payers offer small payments to reward desired clinical practices and performance reporting. The participants agreed that these “P4P” measures, while moving in the right direction, are too marginal to compensate for basic structural problems.

To add a touch of reality to the discussion, others clarified that changes to improve quality inevitably produce losers as well as winners because they cause money to shift hands. For example, a community investment in diabetes prevention would likely reduce the income of specialists who treat the advanced disease, or of hospitals that treat preventable complications of diabetes. Participants stressed that such necessary shifts are a reality that coalitions and communities need to face to keep all stakeholders engaged. This involves candidly anticipating the effects of changes, spreading the benefits as widely as possible, and perhaps compensating the losers.

The group identified a common problem: The national health plans financing health care in many communities are largely absent from regional coalition tables, despite the fact that health plans already benefit from QI more consistently than most other stakeholders. The conferees envisioned possible national strategies to influence national plans by leveraging cultural and political forces to create the

expectation that health plans will support quality improvement and payment reform.

Sustaining and Connecting Regional Coalitions

When they turned to the question of staying power, the participants found that all these regional coalitions, whether new or well-established, are concerned about sustainability and looking for viable business models. A few useful strategies were in evidence. One was establishing support at the outset through substantial state or health plan funding or membership fees, so that coalitions are spared from living year-to-year on grant funding. Another was achieving “branding” as the definitive group setting a region’s quality agenda, thereby strengthening support from funding partners and stakeholders alike. The discussions also highlighted several other strategies for sustainability, described below.

Step up to the Most Challenging Issues

Increasingly, regional QI initiatives are demonstrating their value and consolidating support by being willing to address the community’s toughest health care challenges. Coalitions that focused initially on bringing people together around more modest and achievable goals are being called on to push stakeholders toward more ambitious ones. Often, they concern the value equation—outcomes in relation to cost. It is here that winner/loser dynamics are likely to come into play. The conferees learned about several organizations that have established enough trust, broad participation, and stability to step into the fray and become strong players in their local markets.

Help Manage “QI Chaos”

Regional coalitions are in a good position to coordinate and align the multiple requirements, incentives and measures that originate from different payers and policy makers and add up to “QI chaos” for health care providers. A few participants described their

coalitions' work to facilitate communication among multiple quality improvement programs and devise clear and consistent messages about clinical measures, reporting, and methods of improving care.

Measure and Show Value on a Population Level

The participants turned the “value” mirror on their own activities and acknowledged that to sustain support in their communities, coalitions need to measure and demonstrate their effectiveness in improving health care and population health. At present, the metrics for this kind of self-measurement do not exist; and designing population-level metrics and identifying data sources were flagged as possible joint activities in the future.

Stakeholders Must Network

As intended, the networking conference shed light on a new source of sustainability in the form of mutual learning and support among regional initiatives. The day and a half of sharing demonstrated the many benefits of collaborating on this level. The participants gained a new collective identity as a learning community; became more aware of the synergies between their programs and the federal agenda; identified many new resources and contacts; and began the discussion of possible strategies for joint, national-level action.

Summary

In summary, the overriding messages to emerge from the conference sessions were:

- The urgent need to reform the payment system, identified as the chief obstacle to local and national quality improvement;
- The importance of accelerating efforts to engage all practices in quality improvement activities within regions, regardless of interest and ability; and

- The emerging opportunities for mutual support, shared learning, and collective action across regions.

The conference also highlighted several questions as priorities for future investigation:

- Which strategic elements identified in *It Takes a Region* are essential for achieving real health benefits for the residents of a region?
- What do consumers want and need, and how can they be engaged more effectively?
- How can national plans be brought to regional tables?
- How can regional initiatives measure and show their impact on a population level?

The participants recognized their own and each other's programs as natural experiments that may generate answers to these questions.

In his concluding remarks, co-convenor Dr. Ed Wagner urged the participants to be “relentlessly ambitious” in their work, because mere incremental change will not be enough to improve population health outcomes and the quality of health care and rescue endangered employers. He pointed out the new levels of collaboration that are becoming possible through a confluence of interests among payers, providers, and consumers, and the key roles that conference participants, major professional societies, foundations, and government can play.

Appendix: Participating Organizations

California

Breakthroughs in Chronic Care Program

California Academy of Family Physicians

California Association of Physician Groups

California Cooperative Healthcare Reporting Initiative

California Health Care Safety Net Institute (SNI)/

California Association of Public Hospitals

California Medical Association Foundation
California Primary Care Association
Humboldt Del Norte Independent Practice
Association
Integrated Healthcare Association
Los Angeles County Department of Health Services

Colorado

Colorado Clinical Guidelines Collaborative

Illinois

American Board of Medical Specialties, Research and
Education Foundation

Maine

Maine Quality Forum
MaineHealth

Massachusetts

Massachusetts Coalition for the Prevention of
Medical Errors
Massachusetts eHealth Collaborative
Massachusetts Health Quality Partners

Michigan

Greater Detroit Area Health Council

Minnesota

Institute for Clinical Systems Improvement (ICSI)
Minnesota Community Measurement (MNCM)

New Jersey

Center for Health Care Strategies

New York

New York City Department of Health and
Mental Hygiene
New York State Department of Health
Primary Care Development Corp
United Hospital Fund
Visiting Nurse Service of New York

North Carolina

North Carolina Healthcare Information and
Communications Alliance, Inc. (NCHICA)
North Carolina Office of Rural Health and
Community Care

Oregon

Northwest Physicians Insurance Co.
Oregon Health Care Quality Corporation

Pennsylvania

Pennsylvania Health Care Cost Containment Council
Pittsburgh Regional Health Initiative

Rhode Island

Rhode Island Chronic Care Sustainability Initiative
Rhode Island Quality Institute

Tennessee

Memphis Business Group on Health

Vermont

Vermont Program for Quality in Health Care

Washington

Puget Sound Health Alliance
Washington State Department of Health

Wisconsin

Wisconsin Collaborative for Healthcare Quality
(WCHQ)
Wisconsin Health Information Organization

ENDNOTE

1. Wagner E, Austin B, and Coleman C. *It Takes a Region:
Creating a Framework to Improve Chronic Disease Care.*
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