

## Summary

In recent years, regional coalitions have been developed to promote and coordinate improvement across various levels and types of health care organizations in a geographic area—from individual providers, clinics, and hospitals to managed care plans, networks of providers, and integrated systems. Over the past decade, these initiatives have evolved into a vehicle for achieving both improvements in health care quality and reductions in health care costs. At the core of these coalitions has been a regional organizing body capable of initiating and sustaining collaboration among a wide range of natural competitors.

This study, which was conducted under the auspices of a planning grant awarded by the Robert Wood Johnson Foundation, examines various dimensions of regional health care coalition performance using case study methods and a systems approach. Specifically, it seeks to answer the following research questions:

- Which factors influence the development of sustainable regional health quality coalitions and the decisionmaking processes they use to formulate their goals and activities?
- What are the characteristics of effective collaborative strategies, as judged by their capacity to achieve and maintain positive change as well as to improve quality of health care practices and outcomes?
- What are important barriers to coalition effectiveness, and how might they best be managed?
- What expectations are realistic, with respect to requirements for time, resources, conditions, and actions at policy and systems levels, to be able to institutionalize, and perhaps replicate, practice improvements in a region?

The four coalitions participating in this study represent important “natural” regional health quality improvement experiments that are among the leaders in the country at this time. These coalitions are:

- *Cleveland Health Quality Choice* (CHQC) in Cleveland, Ohio, which discontinued operation in 1999 after almost a decade of publishing health care quality reports on the performance of Cleveland area hospitals;
- *Institute for Clinical Systems Improvement* (ICSI) in Minneapolis–St. Paul, Minnesota, with 10 years of operating experience and continued activity expansion;
- *Rochester Health Commission* (RHC) in Rochester, New York, which has existed for eight years and has significantly modified and expanded its initiatives over time; and
- *Pittsburgh Regional Healthcare Initiative* (PRHI) in Pittsburgh, Pennsylvania, a relatively new coalition still in the early stages of development and evolving rapidly.

To establish an information base on the history and current operations of these four regional coalitions, we collected archival documents from each and conducted on-site and telephone interviews with their key stakeholders. Only telephone interviews were conducted for the CHQC, because it no longer was in operation and many participants had dispersed.

## **Coalition Structures and Activities**

Although the four regions where the coalitions operate have many similar characteristics (see Table 1), each represents a different state of the organizational life cycle, offering a unique opportunity to understand both common and divergent themes across these initiatives that may be more (or less) likely to lead to the desired outcomes.

For each of the four cases, we provide descriptions of the coalition environment, formation, development of goals and strategy, implementation of initiatives, organizational structure and support, major milestones and important changes over time. Although information gathering about the case studies was performed in spring 2002, the three coalitions that are still operating have continued to progress since that time. Therefore, brief updates on their activities since June 2002 are also included.

### ***Cleveland Health Quality Choice—A Life Cycle Completed***

The Cleveland Health Quality Choice (CHQC) program, organized in 1990, was one of the first regional health quality initiatives in the country, becoming a model for similar efforts elsewhere. It was studied by all three of the other regional coalitions in our study during their formative stages.

The goal of the CHQC was to improve the cost effectiveness of hospital care by reporting data on the quality of care provided by local hospitals and encouraging employers and patients to choose high performing providers for health care. The participating hospitals agreed to provide the necessary data and to adopt a standardized method to objectively measure risk-adjusted outcomes.

Little change was made in the CHQC organizational structure, financing arrangements, or program activities in the nine years of its existence. The CHQC focused on establishing the indicators and measurement methodology and then generating regular reports on hospital performance on those indicators.

The CHQC ended its operations in 1999 amidst controversy among participants. Interest in the report cards lagged during the last few years of the CHQC's operation, and the coalition had not evolved as regional and national priorities changed over time. The discontinuation of CHQC may have been a natural endpoint, despite the political upheavals surrounding it.

### ***Institute for Clinical Systems Improvement—Growth and Expansion***

In 1992, the Business Health Care Action Group (BHCAG), a coalition of Minnesota businesses, issued a request for proposals (RFP) to develop an integrated, quality-oriented health care delivery system. Catalyzed by this RFP and to meet BHCAG's request, a proposal was developed by Group Health and Med Centers health plans to merge into a new entity (HealthPartners) and to establish an organization for integrating its associated medical practices, along with the Mayo Clinic. The proposal was awarded by BHCAG, leading to the formation of the Institute for Clinical Systems Integration (ICSI) to develop practice guidelines, measure outcomes, and meet other BHCAG requirements.

The mission of ICSI today is “to champion the cause of health care quality and to accelerate improvement in the value of the health care [they] deliver.” The ICSI program has four principal components:

- *Scientific groundwork for health care* consists of the development of clinical guidelines and technology assessment reports by ICSI member working groups.
- The *core commitment* cycle consists of member provider group participation in four clinical or service-related topics for intensive improvement efforts each year.
- *Support for improvement* is provided to ICSI provider members.
- The *Minnesota health quality agenda* is an outreach initiative to champion health care quality throughout the state.

BHCAG began withdrawing its involvement in 1997. Once BHCAG sponsorship was discontinued, the organization shifted its emphasis from supporting clinical guideline development and managing BHCAG data reporting requirements to supporting guideline implementation and assessment of related outcomes.

In March 2001, four leading Minnesota health plans joined HealthPartners as sponsors of ICSI, better reflecting its regional improvement focus and its statewide improvement goals. This expanded sponsorship has created new challenges for ICSI, both in terms of being responsive to a substantially larger membership and fulfilling specific expectations of the sponsor consortium.

### ***Rochester Health Commission—Evolution and Change***

In response to growing discontent of the Rochester business community about escalating health care costs and premiums, the Industrial Management Council (IMC) (an association of businesses in the Rochester area) began planning for the future of the Rochester health care system, leading to the formation of the Rochester Health Commission (RHC) in 1995. RHC's mission is to help stakeholders reach consensus on actions that are needed to continuously improve the Rochester health care system. The RHC program of work falls under two major areas—Community Performance Assessment and Health Care Forum Initiatives.

*Community Performance Assessment* encompasses a variety of data collection, analysis, and standard development activities designed to assess and improve health care performance across the community. Activities include the following:

- Health System Performance Reports
- Clinical Guidelines
- Employer Health Benefits Survey
- Premium Reports.

The first initiative undertaken by the RHC involved reporting on health plan and provider performance. However, hospitals' unhappiness about providing data on their own performance while helping to support RHC financially led to extended debates among RHC stakeholders regarding its role and authority. Emerging from the debate was a change in the mechanism for funding RHC operations, as well as a decision to create the Health Care Forum, a public forum process through which consensus is achieved on the implementation of community-wide initiatives that are intended to increase the value of local health care services.

*Health Care Forum Initiatives* now constitute the majority of the RHC's work. Through this process, the Forum Leadership Group defined an overarching continuous improvement strategy

for the Rochester health care system. Twelve collaborative initiatives are now under way, led by designated organizations under the Forum that are required to report regularly back to the community on progress in achieving their goals and objectives.

### ***Pittsburgh Regional Healthcare Initiative—Emerging and Framing***

Formed in 1999, the Pittsburgh Regional Healthcare Initiative (PRHI) was derived from a regional economic development plan. PRHI formulated goals for clinical quality, capacity reconfiguration, and patient safety initiatives. It began its work focusing on capacity issues, which threatened providers due to potential loss of competitive positions, leading to their resistance to participation.

PRHI redirected its strategy to develop an environment where providers could feel safe working together on quality improvements. PRHI leaders and staff identified three entry points for change: (1) achieving the goal of perfect patient outcomes in five clinical areas: maternal and infant health, orthopedic surgery, advanced cardiac care, depression, and diabetes; (2) improving the patient safety goal of eliminating medication errors and nosocomial (i.e., hospital acquired) infections; and (3) providing support for quality improvement in the delivery system through working groups and registries and by adapting to health care one of the most successful business improvement models in the world: the Toyota Production System (TPS) and its Pittsburgh derivative, the Alcoa Business System.

Business leadership was prominent initially, but it waned as PRHI initiatives came to be led by physicians and hospitals in the local medical community. At the time of this study in 2002, business leaders were tracking the work and continued to have expectations that PRHI efforts will yield improvements in the health care system.

Initially supported in large part by core funding from the Jewish Healthcare Foundation (JHF) and the Robert Wood Johnson Foundation (RWJF), the bulk of PRHI's current support now comes from several large federal grants. The recent substantial influx of federal grant support has enabled PRHI to significantly increase the number of its full-time staff. An issue to be addressed in the future is how PRHI will be sustained after grant support ends.

### **Key Factors in Coalition Success**

One of the goals of this study was to begin to identify which conditions or factors are important to the formation and longer-term progress of regional health quality improvement coalitions. Factors that appear to be important for enabling the regional coalitions to organize and progress toward their goals include strong leadership; broad-based community commitment; availability of financial resources and incentives; adaptability and flexibility; dissemination of credible, objective, and actionable data-driven information; physician leadership in initiative development; establishing the motivation and active involvement of major providers; achieving measurable outcomes of improvement; and managing the various facets of growth and expansion.

### **Conceptual Model of Regional Health Quality Improvement Coalitions**

Synthesizing our case study findings and the literature on the organization of systems, we develop a conceptual model for the formation and operation of regional health quality improvement coalitions (see Figure 1, Chapter 7). In the context of this model, we present a set

of general observations and related hypotheses, which are formulated around the key components of the model.

Although only four coalitions are examined here, they represent four different stages in the life cycle of an organizational effort, and they yield rich information from which a number of general observations can be made.

### ***General Observations***

- The role, structure, and membership of coalition governance will reflect the coalition's underlying philosophy and approach; the choice of board and committee members from among stakeholder groups signifies the relative importance of various groups in the coalition.
- The size and source of financial support for coalition operations is a signal regarding the extent of commitment being made to the coalition as well as its independence.
- The basic approach and strategy of a coalition is driven by the perspectives of its leaders and the stakeholder groups they represent, while also reflecting external factors such as market competition, local health care issues, or the state regulatory environment.
- A variety of methods may be effective for decisionmaking by a coalition, depending on the sensitivity of the issues being considered and who is participating in the negotiations.
- The presence of an adequately resourced and stable coalition management staff will help ensure that initiatives are carried out and the coalition remains on its defined course.
- A coalition may be representative of a broad range of participants, but providers and insurers will be affected most directly by its decisions and initiatives and therefore must be an integral part of the quality improvement work.
- Achievement of measurable quality improvements will be determined in part by how well clinical initiatives are disseminated from a coalition's active participants to the broader medical community.

### ***Hypotheses***

Another important goal of this study was to identify a set of hypotheses that could serve as a foundation for future research and an information base for potential new coalitions being initiated in the field. Based on the findings from our four case studies, and framed within the context of our conceptual model, we offer the following hypotheses of the formation and operation of regional health quality improvement coalitions.

#### **Coalition Environment**

- Some external catalyst, typically the business community, is needed to give a sense of urgency to coalition formation, but this stimulus does not necessarily have to continue once formation occurs. (Model box 1)
- Coalitions supported by a preexisting collaborative infrastructure (from the business community, government agencies, etc.) will be formulated and accepted more quickly. (Model box 2)

### Coalition Activities

- One or two strong leaders with vision and charisma are needed to bring stakeholders to the table and then to keep them engaged and willing to risk participation during a coalition's uncertain formative years. (Model box 3)
- Successful quality improvement collaborations require funding mechanisms that are sustainable for the long term but do not have an undue effect on coalition objectivity or independence. (Model box 3)
- A coalition is likely to have substantial effects on health care in its region only when top-level representatives of the major health systems and insurers are genuinely supportive of the coalition and are participants in its decisionmaking. (Model boxes 3/4)
- By carefully selecting initiatives that stakeholders agree are both important and feasible to implement, a coalition can achieve early successes that build its credibility, while gaining experience in successful collaborative efforts among the stakeholders. (Model boxes 3/5)
- Coalitions cannot be capable of effective decisionmaking without the guidance of objective sources of (quantitative or qualitative) data. (Model box 4)
- Motivation for providers to proactively participate and internalize initiatives depends on their being a part of the coalition formation and development process, being treated as respected equal partners, and recognizing the benefits of participation. (Model boxes 4/5)
- The leadership of clinicians and their commitment to the coalition's interventions are key to achieving adoption of the interventions in the medical community. (Model box 5)

### Coalition Interactions and Dynamics

- A coalition in which there are a large number and diversity of external and internal interactions among individual stakeholders will have a greater risk of the coalition not being able to achieve its goals. (Model boxes 7/8).
- The ability of coalition participants to reconcile the coalition's collaborative activities with their individual competing roles in the market will enable them to work together effectively (e.g., collaborate on achieving improved clinical processes while competing on outcomes in service delivery). (Model boxes 7/8)
- The early tone and working environment in which a coalition operates, including the style of its negotiations, persuasion, and relationship building, will affect its ability to progress; a sense of fairness, respect, objectivity, and safety in sharing confidential information is necessary for creating an environment of mutual trust. (Model box 8)
- When a coalition is driven by groups external to health care, the motivation of coalition participants will evolve from initially defensive postures to being genuinely participative and internalized, if the coalition achieves collaborative successes and stakeholders see value in the coalition's work. (Model box 8)

### Coalition Status

- An "evolutionary" coalition that effectively modifies its goals and strategies over time in response to changes in members' priorities and the external environment, while adhering to

its basic structure and program principles, will be more sustainable than a coalition with more static functions. (Model box 9)

- Alignment of coalition vision, mission and activities with its stakeholders' clinical practices, financial incentives, or organizational values is necessary for coalition sustainability. (Model box 9)
- A coalition will be sustainable if it continues to yield benefits for the most actively involved stakeholder groups. (Model box 9)

## **Generalizability**

While many of the lessons learned from this study may generalize to coalition efforts in other regions with similar characteristics, it is more difficult to speculate on generalizability to different types of regions (i.e., in different areas of the country, encompassing different-sized Metropolitan Statistical Areas [MSAs]). For example, the community culture of some of the regions in this study may limit the ability to generalize the experiences of their coalitions to other regions. A number of stakeholders reported that their smaller community size contributes to a high level of trust and collaboration among participating stakeholders, because people in the town know each other, trust each other, take pride in their local work, and hold each other accountable for getting things done. The competitiveness and other characteristics of the local health care market will also have important effects on the strategies used by coalitions to engage providers and their successes in achieving changes in practices.

## **Next Steps**

The rich information generated through this study of four regional health quality improvement coalitions highlights the diversity of the goals and programmatic approaches undertaken by these coalitions. At the same time, it underscores a number of features, methods, and issues that are common to most or all of them.

The hypotheses merit further examination, both for the three coalitions described herein that are continuing to evolve and for coalitions operating in other locations. Hypotheses regarding the longer-term sustainability of the coalitions can be tested, drawing on the lessons of this study as well as from relevant theory. It also will be important to examine the extent to which new clinical practices or other interventions generated by a coalition actually diffuse into general practice in the region's health care systems. Further examination of hypotheses regarding the formation of regional health quality improvement coalitions will also be necessary to replicate the information collection we performed in this study for other regional coalitions.

Meanwhile, the information presented in this report should be of use for organizations that are considering launching a regional health quality coalition. The coalitions in this study are among the leaders in the country at this time, and others can "go to school" on their stories and experiences, just as each of them did by studying their own predecessors and each other.