QUALITY & EQUALITY in U.S. HEALTH CARE

A Message Handbook

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PREFACE

The Quality/Equality Message Handbook was created to facilitate consistent messaging about the work of *Aligning Forces for Quality* and other programs and grantees in the Quality/Equality portfolio to lift the quality of health care in America.

The Quality/Equality Message Handbook has messages, facts and figures to tell the story of what is wrong with the quality of health care in America and how we can fix it, with a focus on the work of Aligning Forces for Quality.

The handbook's messages and proof points provide a quick reference and guide for writing talking points, speeches, letters or articles, presentations or other communications. The research is current as of the publication date, and the handbook will be reviewed continually to update the facts and figures used to support the messages or to reflect changes in the program.

In some cases, the Message Handbook takes different angles to address the same topic to offer choices about language.

Where applicable, the messages are presented with supporting facts and figures known as proof points, generally as indented second and third level bullets. We have indicated sources with endnotes, so users who want to explore the topic on their own can do so with the source.

In most cases, these messages are drawn from research about both what's wrong with the quality of our health care system and how to fix it. In some limited cases, such as the messaging about how to talk to the general public and physicians about quality health care and the Aligning Forces for Quality approach to improving quality, the messages have been tested with the target audience through research including focus group and surveys.

CORE MESSAGES

- **Across America, there are dangerous gaps between the health care that people *should* receive and the care they *actually* receive**.
- **In every community, good health care and bad health care is being delivered in hospitals and in doctors' offices.** There are too many mistakes, too much miscommunication and too much inequity in the health care system.
- **We are not getting our money's worth for the $2.3 trillion a year we now spend on health care.** Because we spend so much, Americans mistakenly assume the U.S. health care system is the best in the world. Despite our spending, we do not live as long as people in many other major developed nations—and we have higher infant mortality rates than most.
- **The soaring cost of health care and the growing number of uninsured Americans are the visible problems with the U.S. health system. The *invisible* problem is poor quality.** As we work to make sure everyone can see a doctor when they need to, we must also make sure they get the right care once they do.
- **Poor-quality care comes in three forms: overuse, underuse and misuse.** We give people care they do not need, we fail to give people care that we know works, and we make mistakes that hurt or kill people. We must address all three problems to create a more efficient, equitable and high-value health care system in America.
- **We must lift the quality of care for everyone, everywhere.** The quality of health care people receive too often depends on where they live and the color of their skin. This is unacceptable.
- **More health care is not always better care.** In fact, too much care can harm people by subjecting them to unnecessary dangers and treatments. We need to stop giving and paying for care people do not need. A whopping 30 percent of the care we deliver—nearly $700 billion a year—goes for tests, procedures, doctor visits, hospital stays and other services that may not improve people's health.
- **Health care is delivered locally, but influenced by national AND local factors. We must take action at every level to fix it.**
- **To improve quality, we need better information about the actual performance of doctors and hospitals**. We don't always know who is doing a good job and who is not because we can't see inside the health care system.
- **Everyone who gets care, gives care and pays for care must work together.** First, we must understand the quality of care in every community by measuring and reporting the performance of doctors and hospitals. Then we must implement strategies to help them improve quality. Finally, we must encourage people to act like consumers when it comes to health care so we can create demand for high-quality care and we must encourage patients to become better partners with their doctors in managing their own health care.
- **Our health care system needs to work better for everyone—for the people who get care, for the people who give it and for the people who care for it.** While almost everyone recognizes the need for improvement, we need a clear vision and strong leadership for how we will get there.

WHAT IS QUALITY CARE?

Quality care is the care that people should expect and deserve.

- **Across America, there are serious gaps between the health care that people *should* receive and the care that they *actually* receive.** In every community, good health care and bad health care is delivered in hospitals and in doctors' offices.
- **Quality care is care that works, is safe and is tailored for patients.** The federal Agency for Healthcare Research and Quality defines quality care as "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."[1]
- **Quality health care is**:[2]
  - **Safe:** It does not injure patients; it is supposed to help.
  - **Effective:** It is based on sound science to all who can benefit and refrains from providing services to those who cannot.
  - **Patient-centered:** It is respectful of and responsive to patients' preferences, needs and values.
  - **Timely:** It reduces waiting time and potentially harmful delays.
  - **Efficient:** It does not waste resources.
  - **Equitable:** It does not vary because of someone's race, gender, income or location.
- **For patients, quality care is care that works – based on the best medical research about what has made you ill and what will make you better.** It is getting care when you need it. It is getting all the care you need, and not getting care you do not need. It is safe – it only helps and doesn't harm you. It is tailored to you. And it is delivered by professionals who respect you, communicate clearly with you and involve you in decisions about your care.
- **For many people, having quality care means getting peace of mind, beginning with their relationship with their doctor.** The key is finding the right doctor—one who values relationships based on openness and trust, and who provides high-quality care.
  - For people in good health, good care means care that balances prevention and treating illnesses.
  - For people with chronic conditions, good care means understanding what treatment is proven to work for what condition, and making sure that you're getting that level of care.
  - For people with loved ones who get sick or hurt, good care means knowing where to go to get the best care, without a lot of delays, hassle or misinformation.
  - For people who give care, quality care means that you are able to do your job and help people and systems are designed to help you do that.
  - For all people who receive health care, we all need to learn and act on the differences between good and bad care, just like we want to choose where we live based on how good the schools are or how safe the neighborhood are.

THE PROBLEM OF POOR-QUALITY CARE

Americans are not receiving quality health care.

- **The quality of health care in America is at best imperfect, and at worst deeply flawed**.[3]
- **Compared to care in other countries, U.S. care is high-cost and low-quality**.
  - We spend more in total and more per capita on health care than any other country in the world. But the United States ranks 10th in life expectancy among major industrialized nations and 27th in infant mortality.[4]
- **One problem with quality is UNDERUSE**. We do not give people the care they should get. We neglect to give them medically necessary care or to follow proven health care practices—such as giving beta-blocking drugs to people who have heart attacks.
- **You stand a better chance of getting "heads" on a coin toss than U.S. children have of receiving high-quality health care**—that is, the *right* care, delivered when they need it, from basic immunizations to care for kids with asthma. The situation is only slightly better for adults, who receive a little more than half of recommended care.
  - As many as 91,000 Americans die each year because they don't receive the right evidence-based care for such chronic conditions as high blood pressure, diabetes and heart disease.[5]
  - The lag between the discovery of effective treatments and their incorporation into routine patient care averages 17 years.[6]
  - Adult patients receive only half (55 percent) of recommended care. The percentages of recommended care delivered for some of the most common illnesses include:[7]

- Breast cancer	75.7
- Low back pain	68.5
- Coronary artery disease	68.0
- Hypertension	64.7
- Congestive heart failure	63.9
- Chronic obstructive pulmonary disease	58.0
- Depression	57.7
- Colorectal cancer	53.9
- Asthma	53.5
- Diabetes mellitus	45.4

  - Children receive less than half (46.5 percent) of recommended care. The percentages of recommended care delivered for some of the most common illnesses include:[8]

- Upper respiratory tract infection	92.0
- Allergic rhinitis	85.3
- Acne	56.8
- Fever	51.4
- Childhood immunizations	49.8
- Urinary tract infection	47.8
- Vaginitis and sexually transmitted diseases	44.4
- Asthma	45.5
- Well-child care	38.3
- Acute diarrhea	37.8
- Adolescent preventive services	34.5

- **Another important problem with quality is MISUSE:** We make errors throughout the health care system. Some errors are human, but systems within hospitals, doctors' offices, and elsewhere can be designed to greatly reduce the risk of error.
  - Between 44,000 and 98,000 people die annually from preventable errors—more than from motor-vehicle accidents, breast cancer or AIDS.[9]
  - Health care-associated infections in hospitals account for an estimated 1.7 million infections and 99,000 associated deaths each year.[10]
  - Health care providers make more than 1.5 million medication errors each year, causing an estimated 7,000 deaths annually.[11]
  - Medication errors for hospitalized patients cost roughly $2 billion annually.[12]
  - We tolerate margins of error in health care that are orders of magnitude higher than in other sectors of the economy. Most processes within health care experience 6,000 to 300,000 defects per million opportunities. This compares to error rates of 230 or fewer per million opportunities for world-class manufacturers and fewer than five errors in every million financial-service transactions.[13]
- **A third problem is OVERUSE.** Americans get a lot of health care that we don't know doesn't help them. We often treat people without medical justification—for example, giving antibiotics for simple infections—or fail to follow equally effective options that cost less or cause fewer side effects. No one likes the idea of being denied health care that is necessary and life-saving. But by the same token, we should not want health care that costs far too much without generating any results.
  - Antibiotics are prescribed inappropriately for children's ear infections 13 million times a year—802 times out of every 1,000 doctor visits—despite the finding that more than 80 percent of infections get better within three days without antibiotics.[14]
  - From 1993 to 2003, spending for lumbar fusion (a type of back surgery) rose 500 percent—from $75 million to $482 million—despite a lack of evidence supporting the effectiveness of back surgeries.[15]
  - As many as 78 Medicare patients per 1,000 are hospitalized for conditions like poorly controlled diabetes or worsening heart failure that could have been managed on an outpatient basis.[16]
  - Some regions of the country use vastly more resources to treat patients with similar illnesses without achieving better outcomes. A whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.[17]

Health and health care is worse for specific racial and ethnic groups than for whites.

- **Although the quality of health care is poor for many Americans, some minority patients of specific racial and ethnic groups continue to experience lower-quality health care than when compared to white patients.** This is unacceptable. We cannot improve the quality of health care in America without also closing the gaps in care for minority patients.
  - Racial and ethnic minorities suffer from worse health and receive lower-quality care than whites—regardless of where they live, their income or their health insurance coverage.[18]
  - At no time in U.S. history has the health status of minority populations equaled or even approximated that of whites.
  - The evidence on these disparities in treatment is strongest for African Americans and Hispanics in the United States, and is growing for American Indians.

- With few exceptions, all racial and ethnic minorities experience higher rates of illness and death than non-minorities. For example:[19]
  - African Americans die more frequently from heart disease, cancer, diseased blood vessels in the brain and HIV/AIDS than any other U.S. racial or ethnic group.
  - American Indians disproportionately die from diabetes, liver disease and cirrhosis and unintentional injuries.
  - Hispanics are almost twice as likely as non-Hispanic whites to die from diabetes.

- **Even when access to care is equal, racial and ethnic minorities tend to receive a lower quality of health care than whites**. For example, research has shown:[20]
  - Minorities are less likely to be given appropriate cardiac medications or undergo bypass surgery.
  - African Americans are significantly less likely than whites to receive major therapeutic procedures in almost half of 77 disease categories.
  - Hispanics are less likely than non-Hispanics to receive major procedures in 38 of 63 different disease categories.
  - Racial and ethnic differences in cardiovascular care demonstrate convincingly the evidence of health care disparities.[21]
    - African Americans with coronary artery disease or heart attacks are significantly less likely than whites to receive appropriate procedures or therapies.
    - African Americans are less likely to be catheterized—and if they are catheterized, they are 20 to 50 percent less likely than whites to undergo a revascularization procedure like angioplasty.
    - African Americans are also less likely to receive such recommended medications as beta blockers, blood clot drugs or aspirin.
    - Roughly similar but less consistent disparities have been found for Hispanic patients.
  - African Americans are more than four times as likely as whites to undergo a leg amputation, a devastating complication of diabetes and disease of the blood vessels.[22] A broad array of environmental, social and behavioral factors place patients at risk, including smoking, obesity, a sedentary lifestyle, high blood pressure and lack of access to high-quality primary and specialty medical care.

- **The unequal care is delivered in separate settings.**
  - The five percent of hospitals with the highest volume of African-American patients cared for nearly half of all elderly African-American patients, and the hospitals in the top quartile by volume of patients cared for nearly 90 percent of elderly African-American patients.[23]
    - Those hospitals provided marginally worse quality of care than hospitals that care for a low proportion of African-American patients.
    - Demographic concentration presents an opportunity to improve care for African Americans by targeting efforts toward a small group of hospitals.
  - The five percent of hospitals with the highest proportion of elderly Hispanic patients cared for more than half of elderly Hispanics.[24]
    - Those hospitals are more often for-profit, with higher rates of Medicaid patients and low nurse staffing levels.
    - They provide modestly lower quality of care for common medical conditions.

- As with African Americans, the demographic concentration of Hispanics in a few hospitals presents an opportunity for targeted efforts to improve care.

Care varies widely depending on where you live, for both quality and quantity.

- **People should pay attention to areas of the country where either too much or too little care is being provided, because these factors are related to the overall health and economic well-being of our country.**
  - There are striking variations in the quality and quantity of care that is delivered across the United States. The Dartmouth Atlas project tracks the performance of individual hospitals and their associated physicians as well as regions and states in caring for Medicare patients.
    - There are wide variations in the care provided for chronically ill Medicare patients in their last two years of life that have nothing to do with how ill the patients are. Rather, the variations arise from local, regional and state patterns of medical practice—how often patients see physicians, how often they are referred to specialists, how often the hospital is the site of care for patients with chronic illness, how many days patients spend in intensive care and other resource inputs.
    - The average number of days an elderly person spent in the hospital in the last two years of life ranged from 10.6 in Bend, Oregon to 34.9 in Manhattan. The variation in the volume of care is even more striking for chronically ill patients in the last six months of life, when patients visited the doctor an average of 14.5 times in Ogden, Utah compared to 59.2 times in Los Angeles.[25]
    - These variations in the quantity of services are reflected in the cost. Medicare on average spent $46,412 to care for chronically ill patients in their last two years of life from 2001-2005. The most costly state was New Jersey—at $59,379, or 1.28 times the national average. The least costly state was North Dakota—at $32,523, or 0.70 times the national average.
    - There is even greater variation in spending at the local level, as seen in the nation's 306 hospital referral regions. Spending in the three highest-spending regions—Manhattan, the Bronx and Los Angeles—exceeded spending in the three lowest—Mason City, Iowa; La Crosse, Wisconsin; and Dubuque, Iowa—by almost $46,000 per patient.[26]
  - In many places people do not receive the treatment they should get to help them stay healthy or effectively manage their chronic diseases.
    - There are significant differences in whether people get basic recommended care—such as women getting recommended mammography tests or patients with diabetes getting essential blood tests.[27]
    - In Mississippi, 57 percent of female patients aged 65–69 got regular mammograms in 2004–2005 compared to the national average of 64 percent. Maine fares best with 74 percent.
    - In Alaska, only 71 percent of patients with diabetes got important, needed tests for blood sugar control in 2003–2005, compared to the national average of 84 percent. Vermont fares best with 91 percent.
    - African Americans are far less likely to receive these recommended tests than whites. The study shows 64 percent of the white women in the study got mammograms, compared to 57 percent of African-American women. The study shows 85 percent of white patients with diabetes got the blood sugar control tests, compared to 79 percent for African Americans.
  - There are significant differences in how often patients are admitted to hospitals because their chronic conditions like diabetes or heart failure are poorly managed outside hospitals.[28]

- In the worst state, West Virginia, 116 of every 1,000 patients were admitted to hospitals for these reasons in 2003–2005, nearly one-and-a-half times the national rate of 78 per 1,000. Hawaii fares best with 32 per 1,000.

  - There are significant differences in whether Medicare beneficiaries face tragic health outcomes, such as losing a leg to amputation. Leg amputations are a devastating complication of poor blood circulation and diabetes, and they result from factors that go beyond poor health care.[29]

    - The rates of major leg amputations vary dramatically, and they are far worse for African Americans than whites.

    - In the worst state, Louisiana, 1.66 of every 1,000 Medicare beneficiaries lost a leg to amputation, compared to the national average of 1.14. Utah fares best with a rate of 0.50 per 1,000 beneficiaries. In Louisiana, African Americans lost legs at a rate nearly five times that of whites (6.14 per 1,000 African-American beneficiaries, compared to 1.26 per 1,000 beneficiaries for whites.)

    - In the United States overall, African Americans are losing legs to amputations at a rate nearly five times higher than whites (4.17 per 1,000 African-American beneficiaries, compared to 0.88 per 1,000 beneficiaries for whites).

- **There are wide regional variations in how often people undergo major medical procedures.**

  - Coronary interventions such as angioplasty and stents are used much more frequently in some regions. Rates varied more than tenfold in 2003 among Medicare enrollees, from a high of 42 per 1,000 enrollees in Elyria, Ohio to 3.7 per 1,000 enrollees in Honolulu. [30]

  - People get spine surgery substantially more often in certain parts of the country than others. The overall spine surgery rates among Medicare enrollees in 2002–2003 varied more than six-fold, from a low of 1.6 in Honolulu and 1.7 in Newark, N.J. to a high of 9.4 in Casper, Wyo. [31]

More health care does not mean better health care.

- **There is a significant problem of overuse of health care in America.** This includes putting people in the hospital who may not need to be there, having specialists see patients more often than they may need to or using tests or imaging patients do not need.

  - The extent of over-care is apparent by looking at spending and outcomes. Some regions of the country use vastly more resources—hospital stays, doctors' visits, imaging and tests—to treat patients with similar illnesses without achieving better outcomes. As a result, researchers estimate that a whopping 30 percent of health care spending is for services that may not improve people's health—nearly $700 billion a year.[32]

- **Higher spending does not achieve better outcomes**.

  - Both doctors and patients often assume that more "care"—that is, using every available resource such as specialists, hospital and ICU beds, diagnostic tests and imaging—produces better outcomes for patients. This is wrong.

  - The regions of the country that spend the most money on health care per capita deliver more health services. In higher-spending regions:[33]

    - There are one-third more hospital beds and physicians per capita.

    - Patients have more hospital stays, doctor visits, specialist referrals, imaging, minor tests and procedures.

- Higher spending does not produce better outcomes. In higher-spending regions:[34]
  - Patients get the care recommended by experts less frequently.
  - There are slightly higher death rates following heart attacks, hip fracture and colorectal cancer diagnosis.
  - Patients have worse access to care and longer waiting times.
  - There is no difference in patient-reported satisfaction with care.

- **The evidence that the outcomes and quality of care tend to be better in regions that use fewer resources carries important policy implications** for Medicare and U.S. health care in general. Health care organizations serving such regions are not withholding care that patients really need. On the contrary, they are simply more efficient. They achieve equal and often better outcomes with fewer resources. They offer a benchmark of performance toward which other systems should strive.
  - Dartmouth researchers compared care across the country to the care provided by the prestigious Mayo Clinic and found that if the entire country practiced medicine the way the Mayo does in Rochester, Minnesota, Medicare could have saved $50 billion from 2001–2005 on the patients in this study.[35] The savings would be far greater for Medicare as a whole.
  - These potential savings are highly significant given the current Medicare fiscal crisis—and not spending this money wouldn't have compromised the quality of care.
  - The current payment system rewards higher volumes of services, whether they are warranted or not. We must reward, rather than penalize, provider organizations that successfully reduce excessive care and develop broader community-based strategies for managing patients with chronic illness.

SOLUTIONS TO THE QUALITY PROBLEM

Health care is delivered locally, but influenced by national AND local factors. We must take action at every level to fix it.

- Getting quality health care is a national issue. It's a local issue. It's everyone's issue. **Everyone who gives, gets or pays for care should care about improving quality.**
- **Consumers and patients should care about quality because they want to get better when they see a doctor or go to the hospital, not worse**, so they need to understand that some providers have better track records than others.
- **Doctors and nurses should care about quality because they want to provide the best possible care for people**, and they need to know the outcomes they are achieving and the effectiveness of their local health care system.
- **Employers, the government and everyone else who pays for health care should care about quality because they expect greater value for their money.**
- **We must drive quality improvement by aligning key players in local communities.** No single person, group or profession can improve health and health care throughout a community without the support of others. Those who get care, give care and pay for care must work together to create a health care system that rewards and promotes better health and health care.
- **There are three fundamentals to improving quality: performance measurement, quality improvement and consumer engagement.**
  - We must measure and report information about the performance of health care providers to everyone who gives care, gets care and pays for care.
  - We must help doctors' offices and hospitals improve their quality.
  - We must encourage people to act like consumers when it comes to health care so we can create demand for high-quality care. We also must encourage patients to become better partners with their doctors in managing their own health care.

PERFORMANCE MEASUREMENT AND PUBLIC REPORTING

To improve quality, we need better information about the actual performance of doctors and hospitals.

- **Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care.** We don't always know who is doing a good job and who is not because we can't see inside the health care system.
  - **Patients need information** about the quality of care that doctors and hospitals provide if they are going to make informed choices about their own care.
  - **Doctors and hospitals need information** about the quality of care they provide if they are going to improve it. You cannot improve what you do not measure.
  - **Consumers and purchasers need information** about the value they are getting for their health-care dollars.

- **Making health care patient-centered starts with giving consumers accurate information that they can use to make informed choices**. Choosing the right doctor or hospital is one of the most important health care decisions consumers will ever make, yet they have precious little information to guide the decision:[36]
  - Only 20 percent of Americans surveyed in 2008 said they had seen quality information about hospitals and only 7 percent said they used the information to make a decision.
  - Only 12 percent of Americans surveyed in 2008 said they had seen quality information about doctors and only 6 percent said they used the information to make a decision.
- **Consumers want information to support their health care decision-making.** [37]
  - Eighty-eight percent of consumers say they would search for information on treatment options if they were diagnosed with a medical condition.
  - Four out of five consumers (81 percent) believe that, if needed, they would search for information on their own about physicians or hospitals.
  - Nearly two-thirds of consumers surveyed (64 percent) feel it is important to obtain health information from sources in addition to their doctor.
  - Two-thirds of consumers who have made various health care decisions in the past year—such as selecting a primary care physician, a specialist, a hospital or a treatment option—have sought out information to make that decision.
- **Consumers want information about "quality of doctor care" from Web sites.**[38]
  - Nine percent say they have used the Web for this purpose.
  - Sixty-seven percent say they are interested in using the Web for this purpose.
  - Eleven percent are willing to pay extra for this service.
- **Most doctors lack information about the quality of care they or their colleagues provide.**[39]
  - Only one doctor in three gets any data about performance.
  - Only one in four gets patient survey data.
  - Only one in five gets process-of-care data.
  - Fewer than one in five get clinical outcomes data.
  - Only one in seven solo practitioners has access to *any* quality data.
  - The overwhelming majority of doctors in practices with fewer than 10 MDs cannot generate internal data.
- **We should develop robust collection systems for data on the quality of care delivered by doctors, medical groups, hospitals, nursing homes and other providers.**
- **Reporting systems must be independent and trusted by physicians and consumers alike.**
- **Doctors are understandably concerned about measurement and reporting**. But leading physicians also recognize the problems with health care quality and understand the need for medicine to embrace quality-improvement techniques. We must work together for measurement and reporting that is fair and accurate.
- **Measurement and reporting are critical to quality-improvement efforts.** The saying "you can't improve what you don't measure" certainly applies to health care. While physicians, nurses, clinics and

hospitals work to deliver high-quality care, they need sufficient information to help them identify areas to target for their quality-improvement efforts.

- **Measurement and public reporting can foster quality improvement even if consumers do not routinely act on the data**. Providers feel competitive pressures and fear a loss of market share could result from a damaged reputation.
- **Measuring and reporting on the performance of doctors and hospitals is here to stay**. Medicare, employers and health plans have made it part and parcel of reimbursement strategies or benefit design. The number of regional organizations also reporting on the performance of hospitals and doctors is growing.
- **Programs to measure doctors' and hospitals' performance must be consistent nationally**. We don't want "good health care" to mean one thing in Miami and another in Seattle. At the same time, we must strike a balance between standardization and innovation. We want measurement based on sound national standards and methodology, but we must also permit variations in what is measured and reported to meet the needs of individual communities.
- **At the community level, we can improve the quality of health care by**:
  - **Providing information on the quality of care local doctors and hospitals provide so that consumers can make better decisions** about where to get care for themselves and their family.
  - **Helping people take an active role in learning about their health and their providers** so that they have the information they need to choose the right doctor for them.

Measuring the quality of care is especially important for reducing racial and ethnic disparities.

- **Racial and ethnic disparities in health care can in part be addressed by measuring how care is delivered to different patient populations**, then implementing targeted efforts to close the gaps.
  - While factors such as poverty, racism and personal health behavior contribute to disparities in health care, these factors are very difficult to influence, but factors such as how or whether a doctor or hospital delivers consistent, quality health care can be evaluated and influenced through specific systemic changes.
  - One way to effectively address and reduce racial disparities in health care is to collect and track patient data by race and ethnicity, evaluate the disparities in treatment that are found, and design interventions that will appropriately and consistently increase quality.
  - Identifying and testing specific interventions to improve quality—then measuring the impact of these interventions when they are consistently delivered to each racial/ethnic group—can help determine what works best for specific racial and ethnic groups.
- **Health care systems need better tools to address racial and ethnic disparities in health care**—such as how to effectively use data to target disparities and improve language access.

CONSUMER ENGAGEMENT

There is a lot that people can do to improve the quality of care they receive. They can make informed choices about their health care and become better partners with their doctors in managing their own health.

- **The choices people make about their health and health care profoundly affect outcomes and cost**. That is why we need consumers to:
  - Understand the behaviors that put them at risk and, for those who do have an illness, understand how they do help manage it.
  - Work with their doctors to understand and make informed choices about treatments.
  - Understand the difference between good care and bad care—and demand good care.
  - Choose doctors, clinics and hospitals based on information about their ability to deliver effective care.
- **People who are actively engaged in their health care have better outcomes.**
  - The degree to which people are able and willing to take on the role of managing their health and health care—their level of activation—plays a critical role in their health outcomes.
    - The more activated a patient is, the more likely she is to obtain preventive care such as health screenings and immunizations, and to adopt healthy behaviors such as eating right, exercising, monitoring her condition and following treatment, asking questions of providers and using quality information to select a provider.
  - Some health care delivery systems are better at supporting patients in self-management activities than others. Those that focus on the patient, such as practices built on the "medical home" model or those that use the chronic-care model, do best because they can offer coordinated and customized care aimed specifically at activating patients, such as dedicating specific staff to support patients.
- **There is more information than ever about the performance of hospitals and doctors, and more is coming online, but some of it is hard for people to understand and use. When picking doctors and hospitals, we need to help people get and use reliable information about the quality of physicians and hospitals.**
  - People are eager for information, but want it to be non-technical and based on patients' personal experiences with physicians and hospital staff members.
- **At the community level, we can improve the quality of health care by:**
  - **Exploring new ways to improve communications and coordination** between hospitals, doctors, nurses and patients.
  - **Giving people information that helps them be better partners with their doctors** in managing their own health.

QUALITY IMPROVEMENT

Through quality improvement programs, we can pinpoint areas where there is overuse, underuse or misuse of care and systematically develop solutions.

- **Our current health care system uses outdated methods to deliver care and, as a result, encourages unnecessary care in a high-cost, poor-quality environment**. Unless we rapidly make both easy-to-implement and more complex improvements, we will continue to squander precious resources on a broken system.
- We should redesign care settings to encourage medical providers to work in teams.
  - We should encourage providers such as physician assistants, nurses, nutritionists and dietitians to take a leading role in quality improvement.
- Quality improvement is implementing techniques and protocols that allow doctors and hospitals to raise the level of care they deliver to patients.
- Many efforts to improve care have resulted in measurable, real changes in actual hospitals and doctors' offices. These changes resulted in patients getting the care they needed, when they needed it. Now, health care needs to be transformed on a bigger scale. Cities, states and our country as a whole need to make health care reform a top priority.
  - Evidence-based quality improvements have begun to take hold—progress that is saving not only money, but lives. Across the country, new models of care are emerging, built on fast-expanding knowledge regarding effective and efficient delivery of care. They include innovations for preventing people in hospitals from getting infections, to making sure heart-attack patients get the right medications when they enter the emergency room, to making sure a patient with diabetes gets the right annual checkups.
- **Institutions can apply quality-improvement techniques to health care on an ongoing basis and spread learnings throughout their system**. They can study how their systems permit and even facilitate errors. They can improve care by measuring their practices against proven best practices and determine where they fall short or exceed those standards of care.
- **Nurses play a central role in ensuring the quality and safety of hospital care as highly trained professionals regularly at the patients' bedside**. As such, nurses are at the forefront of the quality-improvement movement in hospitals.
  - Hospitals' pursuit of high-quality patient care is dependent, at least in part, on their ability to engage and use nursing resources effectively.[40]
- **At the community level, we can improve the quality of health care by:**
  - **Showing doctors and hospitals how they can make improvements in caring for patients**, so that people receive better care and have closer relationships with their doctors.
  - **Pinpointing areas in the health system where medical errors often occur and developing solutions** to reduce these errors.

REWARDING QUALITY CARE

Our payment system should reward providers for giving patents the right care at the right time the right way.

- **Our health care system generally pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions**. It is not designed to reward better quality or to support care coordination or prevention.
  - Our current reimbursement system can create perverse outcomes. Consider:
    - There are 24 million Americans with diabetes.[41]
    - Nationally, many insurers will not pay $150 per visit for a diabetes patient to have routine preventive-care visits with a podiatrist.[42] However, nearly all insurers will pay $30,000 for the foot amputation that is all too common in advanced cases of diabetes.
- **Public and private payers—health plans, Medicaid and Medicare—should use common measures to assess provider performance.**
- **Providers who deliver high-quality, cost-effective care or who improve significantly should be rewarded.**
- **Providers should be fairly compensated for preventive care, time spent coaching patients and coordinating care for those with chronic conditions.**
- **Payers should consider paying by episode of care rather than quantity of services**. This means paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each treatment.

QUALITY AND HEALTH REFORM

Now more than ever, improving the quality of health care in America is critical. Poor quality health care robs the system of precious resources—in both dollars and services—that could be used to expand access and coverage.

- **The problems of poor-quality health care in America and the millions of uninsured Americans are inextricably linked**.

- **The soaring costs of U.S. health care—projected at $2.3 trillion in 2008, more than 16 percent of our GDP—is putting access to health care out of reach** for many ordinary families, and putting programs like Medicare and Medicaid at grave risk.[43] Health insurance for a family now averages $12,680.[44]

- **Poor or uneven quality of health care robs the system of precious resources—in actual dollars and services—that could potentially be used to expand access and coverage.**
  - Researchers estimate that a whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.
- **If policymakers want to help more people get better care, especially in the context of an economic recovery, we must determine how to stop wasting money on inappropriate or unnecessary care, and how to deliver the care that people want and need.**
  - The current payment system rewards both oversupply of certain health care services and volume. We must reward, rather than penalize, health care providers that successfully reduce excessive care. We must also reward health care providers for providing the right care at the right time.
  - Poor-quality care comes in three forms: overuse (too much health care, based on available supply), underuse (not enough health care for people who need it) and misuse (medical mistakes). We need to address all three problems to create a more efficient, equitable and high-value health care system in America.
- **Improving the quality of care for patients with chronic illness would go a long way toward freeing up dollars for expanding coverage, and promoting a healthier economy overall.**
  - Three in four dollars spent on health care in the United States are for patients with one or more chronic conditions, like diabetes, asthma, heart disease or depression, nearly $1.6 trillion of the $2.1 trillion spent on U.S. health care in 2006. Research shows that these patients receive only 50 percent of the care recommended by experts and doctors.
  - 74 percent of private health insurance spending goes for the 45 percent of privately insured people who have chronic conditions.
  - In 2004, hospital costs for potentially preventable chronic conditions totaled nearly $29 billion—one out of every 10 dollars of total hospital expenditures. As many as 4.4 million hospital stays could possibly be prevented by taking better care of people outside the hospital, by improving access to effective treatment or patient adoption of healthy behaviors.
- **Right now, we do not have an easy way to reallocate the dollars that are going into poor-quality health care and apply them to other causes, like expanded access.**

- **To get to health care that is high-quality AND delivers better value for everyone, we need to make sure that the stakeholders who give care, get care and pay for care are part of the solutions.**

Otherwise, reform efforts will be doomed by the morass of economic and political incentives that often cause health care stakeholders to operate at cross-purposes.

- ***Aligning Forces for Quality*, a national initiative of the Robert Wood Johnson Foundation, is working to lift the overall quality of care in 14 communities**, by focusing on three things: 1) engaging stakeholders to measure care and publicly report on the quality of care; 2) helping doctors, nurses and other health care professionals learn how to deliver better care; and 3) helping consumers and patients become more engaged in the quality of care they can demand and receive.
    - In addition to Aligning Forces, the Robert Wood Johnson Foundation and others are actively testing better ways to measure and pay for care. We need business leaders, policymakers and payers to work with us on the solutions, so our health care industry can promote the health of people AND the economy.

MESSAGES EXPLAINING ALIGNING FORCES FOR QUALITY

Aligning Forces for Quality **is RWJF's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.**

- ***Aligning Forces for Quality*****, a long-term, comprehensive effort to improve the quality of care on the ground, in communities, is the signature program in the Robert Wood Johnson Foundation's $300 million commitment to improve the quality of U.S. health care.**
- **While health care quality is a national problem, health care is delivered locally** and fixing it requires local action.
- **RWJF's unprecedented commitment** of resources, expertise and training will turn proven practices for improving quality into real results in communities.
- **14 regions across the country have already been selected** to participate in this program, with six additional regions potentially being added.
- **These communities are positioned to make fundamental and cutting-edge changes** to re-build their health care systems.

We are taking specific actions to improve the quality of health care in communities.

- ***Aligning Forces for Quality*** **asks people to work toward fundamental goals that will lead to better care.**
- **The program will:**
  - **Help physicians improve** the quality of their care.
  - **Encourage people** to become better partners with their doctors.
  - **Improve care inside hospitals**, with a special focus on the role nurses play.
  - **Reduce inequality in care** for patients of different races and ethnicities.

Together we will align forces to improve the quality of health care.

- **We seek to drive higher quality care by aligning the key players** and market forces within a particular geographic region.
- **Doctors, nurses and hospitals want to deliver high quality care**, but the fragmented nature of our health care markets and delivery systems often prevent key players from working together toward that common goal.
- **We are teaming up with those who get care, give care and pay for care** to deliver lasting change for entire communities.
- **We know that given today's complicated health care system, it is hard to believe that anything can actually change—but we are confident that this effort will work** in communities if we have everyone's help.

MESSAGES FOR SPECIFIC AUDIENCES

MESSAGES FOR DOCTORS

- **The most trusted agent in health care today is the physician.** And the cornerstone of quality care is a "healthy" physician-patient relationship that helps patients become more knowledgeable about and involved in their health behaviors and medical care.
- **We must close the gap between the quality of health care that people now receive and the even better care that we know doctors and other health care providers are capable of delivering.** We want to go from good to great, and no one is more important than doctors as we reach for the next level.
- **We need doctors to:**
  - **Help fellow physicians and health care providers improve their own care delivery.**
  - **Help patients understand their responsibility to recognize and seek high-quality care, and to improve their health behaviors and compliance with treatment plans.**
  - **Help measure and publicly report their performance.**
- **We understand the frustration of doctors who feel squeezed by today's payment system, pressured to see more patients, and frustrated by growing administrative requirements.** We want to work toward a system that rewards doctors for getting patients the high-quality care they need – care that is known to improve health and reduce unnecessary risks.
- **In the past, some systems that collected data on the quality of health care were flawed.** To improve quality, we need physicians to help design a system that is fair, inclusive and gets it right.
- **Publicly reported information about physician and physician group performance is critical for improvement.** As performance measures are developed, they must be:
  - Transparent in methodology.
  - Specific about the data used to develop the measures and any limitations presented by the data.
  - Inclusive of physicians from the beginning.
- **In every community, both good and bad care is being provided in hospitals and doctors' offices.** If we can all agree on a reliable, comprehensive and accurate way to measure physician performance, that's a worthwhile goal.
- **Many physicians look for new ways to improve their skills and provide better quality care.** Sharing performance data across providers often generates conversations about proven techniques that improve care.
- **Performance measurement data can help physicians assess what is working in their own practice.** Most physicians don't have accurate, complete data on the care provided in their practice. Without measurement, it is hard to know if the steps they are taking are as effective as they want them to be.
- **We think performance measurement could benefit most physicians.** It could result in identifying ways to improve the quality of care across their entire practice. It could also help them assess the quality and effectiveness of the care that they provide and how it compares to evidence-based standards of care.
- **The efforts now underway in many communities emphasize improving patient compliance, instead of just focusing on physicians.** These efforts include educating patients to better manage their disease and to take more responsibility for improving their health.

- **Local physicians are included in the team that designs the measurement system**, to help ensure that it's fair, inclusive, flexible and actually measuring the right things.
- **While reviewing and acting on the data requires extra attention from physicians, the added effort will lead to better care for patients.** In some communities, efforts to implement performance measurement involve aggregating data from various health plans to give physicians a simpler, comprehensive picture of their care.
- **Our work also includes quality improvement training (continuing medical education) about how to use and act on the performance information to help physicians make practice improvements.**
- **Every physician knows there are different ways to measure care and different sources of data to look at, much of it contradictory.** There are so many different players involved that the requests for physicians to report their data has become increasingly burdensome for the practice and often meaningless for improving patient care. We need to streamline the process and get everyone who collects data on the same page to aggregate their results so that we get a comprehensive and accurate look at trends that we can act upon.
- **Some of the nation's leading medical societies—AMA, AAFP, ACS, ACOG, AAP and many other specialty societies— are at the table because they recognize the inevitability of performance measurement and want to shape it.**
- **We need physicians to be part of a team that designs the performance measurement system, instead of leaving it only to administrators, actuaries and politicians.**

MESSAGES FOR THE PUBLIC

- **One of the most powerful forces driving improvement in health care is the educated consumer.** Consumers who make informed choices and are engaged in their own care not only experience better health outcomes, they also help reward doctors, hospitals and health plans that deliver better care and service.[45]
- **Finding the right doctor can be tough in a confusing health care system.** Many people don't have close relationships with their doctors anymore, and the journey toward good health can leave some people feeling uneasy about the care that they receive.
- **Most doctors are pressed for time these days, and patients feel like they don't have time to really talk and ask their doctors questions**. Rushed doctor visits can leave people with lingering concerns about their symptoms, treatments or medications.
- **Getting good medical care is a worry for many people.** There are too many choices and not enough clear, trustworthy information.
- **In every community, both good and bad care is being provided in hospitals and doctors' offices.** There are too many mistakes and too much miscommunication in the health system that can negatively affect people's lives.
    - We need to explore new ways to improve communications and coordination between hospitals, doctors, nurses and patients.
    - We need to give people information that helps them be better partners with their doctors in managing their own health.
- **Getting peace of mind about health care begins largely with finding the right doctor—one who values relationships based on openness and trust and provides high-quality care.** We need to

provide consumers with information on the quality of care local doctors and hospitals provide, so they can make better decisions about where to get care for themselves and their families.

- **We need local teams of doctors, nurses, hospitals, employers, insurance plans and residents working together to make improvements that will help people get better care**.
  - These teams can show doctors and hospitals how they can make improvements in caring for patients, so that people receive better care and have closer relationships with doctors.
  - These teams can pinpoint areas in the health system where medical errors often occur and develop solutions to reduce these errors.
- **Given today's complicated health system, it is hard to believe that anything can actually change—but we are confident that we can improve health care if we have everyone's help**. No one is more important to this effort than consumers:
  - Quality health care happens when people take an active role in their own care, becoming partners with their doctors to create a more effective, trusting relationship that helps them stay healthy or determine the right care when they need it.
  - Regardless of what kind of relationship they have with their doctors, there is a lot that people can do on their own to manage their own heath, such as watching what they eat, exercising and limiting stress.
  - People can improve their care by learning more about their doctors and their own conditions—asking questions, sharing their medical history, making sure they understand their doctors' recommendations and taking the necessary steps to feel better sooner.

MESSAGES FOR EMPLOYERS

- **As the largest purchaser of health care in America, private employers are footing the bill for poor-quality care and must demand better quality.**
- **High-quality care makes better and more efficient use of employers' health care dollars.** Improving the health care delivery system's outcomes now creates an opportunity to reduce premiums in the future.
- **We need businesses—the people who purchase health care—to help create a healthier and more productive workforce, and increase accountability for the delivery, purchasing and consumption of health care.**
- **Employers pay a price for poor-quality care.** About six in 10 Americans get health insurance through employers, and employers pay for nearly three-quarters of premiums. At the same time, poor quality costs a typical employer between $1,900 and $2,250 per employee every year.[46] A staggering 30 percent of U.S. health care spending—$700 billion—is the result of poor quality care, chiefly overuse, misuse and waste.
  - Nearly three-fourths of the money spent by private insurance goes to treat people who suffer with chronic illnesses such as diabetes, asthma, heart conditions and depression. Yet, Americans get only half of the recommended care for their chronic conditions—and too many people do not take personal responsibility for managing their health.
- **Helping employees manage their health is a sound investment in human capital.** Health promotion and disease management can lift the quality of the workforce. Put simply, employees who feel good work better. Employees who are well are more likely to show up than employees who are sick—and healthy employees perform better on the job.

- While the total direct cost to U.S. business for health care was $450 billion a year in 2004, the indirect cost of productivity losses arising from personal or family health problems adds another $225.8 billion. Poor quality care leads to as many as 45 million avoidable sick days, the equivalent of 180,000 full-time employees—or everyone who works in Salt Lake City—calling in sick every day for a full year.[47]

QUALITY AND THE UNINSURED

High costs and the uninsured are the visible problems with U.S. health care. The *invisible* problem is poor-quality care.

- **The problems of the quality of care and access to care and coverage are inextricably linked**, even though few understand the link.
  - There is a clear-cut linkage between improving quality and managing costs. Poor quality care robs the system of precious resources—dollars and services—that could be used to expand access and coverage.
- **The soaring cost of U.S. health care is putting access to health care out of the reach** for many ordinary families and putting programs like Medicare and Medicaid at risk.[48] America spent $2.2 trillion on health care in 2007 (nearly 16 percent of GDP) and spending is expected to hit $2.3 trillion in 2008.[49] Health insurance for a family of four now averages $12,680 a year.[50]
  - For most people, health care reform is about getting everyone access to care, and the debate is over how to slow fast-rising costs and increase the number of people with insurance coverage.
  - The soaring cost of U.S. health care—$2.2 trillion in 2007 and nearly 16 percent of GDP—is putting access to health care out of the reach for many ordinary families and putting programs like Medicare and Medicaid at risk.[51] Health insurance for a family now averages $12,680.[52]
  - As we think about how to cover more Americans, we must also change the way we deliver and pay for health care in this country.
    - We know that improving the quality of care—getting people the right care at the right time, especially if they are chronically ill—will cost less, not more, over time.
    - We also know that the same health care system that gets some people too little care too late also gives some people more care than they need.
    - The extent of inefficiency in the U.S. health care system can be seen by examining health care spending versus results, especially across geographic regions. Some regions of the country use vastly more resources—hospital stays, doctor visits, imaging and tests—to treat sick patients. Others use far fewer resources to treat similarly ill patients, and get the same results.
    - Researchers estimate that a whopping 30 percent of health care spending—nearly $700 billion a year—is for services that may not improve people's health.[53]
- **Good health is not only equitable; it is also efficient, effective and safe**. What happens to patients *after* they get in the doctor's office or hospital is as important as getting them in.
- **To get to health care that is high-quality AND delivers better value for everyone, we need to make sure that the stakeholders who give care, get care and pay for care are part of the solutions.** Health insurance is important to getting quality care for children. Children in states with the lowest rates of uninsured children are more likely to get preventive care like medical and dental checkups and see doctors who coordinate their care.[54]

MESSAGES ABOUT THE AF4Q LANGUAGE COLLABORATIVE

All hospitals are required to provide language services to patients who speak limited English, but there is little guidance on the most effective ways to communicate with these patients.

- All hospitals are required to provide language services to patients who have limited English proficiency, at no charge to the patient.
  - Hospitals are meeting this requirement in a variety of ways—but are doing so without federal guidance, uniform standards or agreed-upon systems for assessing the quality of the language services they provide to patients.
  - Many hospitals throughout the nation want to share information on how they provide language services to their patients so that they can learn from each other, assess their own programs and improve the services they offer.

When patients and health care providers are not able to communicate clearly and thoroughly with each other, the quality of care suffers.

- Research shows that when patients have difficulty communicating with their health care providers, they do not receive the best care possible, because they are far less likely to understand their conditions, or adhere to medication and disease management recommendations.
  - At the same time, these patients are unable to communicate important information to their health care providers, which can result in missed diagnoses, and even medical errors.
  - As a result, more hospitals are recognizing that the quality of language services that they provide is linked to the quality of medical care that these patients receive.

Just as any patient expects care from a trained, qualified health care professional, a patient with limited English proficiency should expect that language services be provided by professionals who are specially trained in interpreting health and medical information.

- Providing effective language services requires skills beyond just the ability to speak another language. Although there is no uniform standard, experts agree that language services are best provided by people who have been trained in these skills and whose abilities in this arena have been formally assessed.
  - Many health care professionals are themselves bilingual and bicultural and can relay information to patients in their own language, which sets the stage for an effective environment for communicating. Even bilingual providers, however, should be assessed for language proficiency. If they sometimes serve as an interpreter, they also should receive training before providing these services to patients.

Aligning Forces for Quality **offers a Language Collaborative for participating hospitals to work together to identify, test and assess strategies for hospitals to provide timely, effective language services to patients with limited English proficiency.**

- Funded by the Robert Wood Johnson Foundation and staffed by experts from The George Washington University, the Language Collaborative is one of the Foundation's many programs to identify effective ways of reducing racial and ethnic disparities in the quality of patient care.

- The Language Collaborative uses a tested, rigorous quality improvement measurement process to look at how these hospitals communicate with non-English-speaking patients—and how they can improve their services.
- The hospitals will participate and collaborate through a 'learning network' structure to test new ideas, quantify results and share lessons learned. Program successes will be shared nationwide, giving hospitals with linguistically diverse patient populations concrete and tested examples of effective language services programs and interventions that they can adopt in their own busy hospital environments.
- The program focuses on how hospital staff can better structure and manage language services programs in order to have effective, efficient and timely communication with patients who speak little English.
- The Language Collaborative has four key goals:
    1. Improve communications between health care providers and patients with limited English proficiency.
    2. Work with hospitals to develop models of high-quality language services.
    3. Enable hospitals to create performance benchmarks and conduct ongoing measurements of effectiveness.
    4. Encourage the spread of successful strategies to increase language services capabilities within hospitals and across health systems.

MESSAGES ABOUT THE AF4Q EQUITY COLLABORATIVE

Although the quality of health care is poor for many Americans, specific racial and ethnic groups continue to experience lower-quality health care when compared to white patients.

- Racial and ethnic disparities in health care are measurable differences in the range of medical services that are provided to people in the U.S. based on their race or ethnicity.
  - The evidence on these disparities in treatment is strongest for African Americans and Hispanics in the United States, and is growing for American Indians.
- While the quality of care a patient receives often varies depending on social and economic factors, such as geographic location and health insurance status, numerous research studies show that African Americans and Hispanics are likely to receive a lower-quality of treatment than their white counterparts—even when health coverage and income levels are equal.
  - In 2002, the nonpartisan and well-respected Institute of Medicine issued a groundbreaking report entitled "Unequal Treatment," which provided evidence that racial and ethnic minorities were more likely to receive lower-quality care than whites, particularly when treating heart disease and cancer.
  - Numerous research studies released subsequent to "Unequal Treatment" indicate that three years later, little has been achieved in reducing these disparities.

Many people believe that the issue of racial and ethnic disparities in health care can in part be addressed by measuring how care is delivered to different patient populations, then implementing targeted efforts to close the gaps.

- Factors such as how or whether a doctor or hospital delivers consistent, quality health care, can be evaluated and influenced through specific systemic changes.
- One way to effectively address and reduce racial disparities in health care is to collect and track patient data by race and ethnicity, evaluate the disparities in treatment that are found, and design interventions that will appropriately and consistently increase quality.
  - Health care systems must account for patients' race and ethnicity in order to better meet the challenges of delivering quality health care that is most appropriate for diverse patient populations.
  - Identifying and testing specific interventions to improve quality—then measuring the impact of these interventions when they are consistently delivered to each racial/ethnic group—can help determine what works best for specific racial and ethnic groups.
- Health care systems need better tools—like how to effectively use data to target disparities and improve language access—to address racial and ethnic disparities in health care.

Aligning Forces for Quality **offers an equity Collaborative that will identify and address racial and ethnic disparities in cardiac care, and test real-world solutions in communities across the country.**

- Funded by the Robert Wood Johnson Foundation and staffed by experts at The George Washington University, the Equity Collaborative is an important part of the Foundation's strategy to reduce racial and ethnic disparities in health care.

- The Equity Collaborative focuses on improving cardiovascular care for African-American and Latino patients in both inpatient and outpatient settings.
- The Equity Collaborative will lead hospitals through a collaborative effort to systematically measure and enhance the quality of cardiac care provided to their patients.
- The hospitals will participate in a "learning network" to test new ideas, quantify results and share lessons learned. Program successes will be shared nationwide throughout the four-and-a-half year initiative and potentially adopted at hospitals and medical centers across the country.
- The hospitals will also work with community-based clinics—using innovative approaches to improve the broader continuum of cardiovascular care for racial and ethnic minorities.
- The ***Equity Collaborative*** has four key goals:
    1. Improve cardiovascular care for African Americans and Hispanics;
    2. Develop effective, replicable quality-improvement strategies, models and resources;
    3. Encourage the spread of those strategies and models to clinical areas outside of cardiac care; and
    4. Share relevant lessons learned with other hospitals and across health systems.

The opportunity to make a difference in cardiac care is particularly strong.

- African Americans and Hispanics are less likely than whites to receive cardiac therapies and procedures – even when patient characteristics, such as age, gender, income, health coverage status, co-morbidities and disease severity are similar.
    - There is particularly strong evidence of racial and ethnic disparities in cardiac care.
    - The recommended standard of care for cardiac patients is clear.
    - The measurement tools to determine whether heart disease patients are receiving the recommended standard of care have already been developed and tested.

MESSAGES ABOUT THE AF4Q TCAB COLLABORATIVE

Most of the country's inpatient care is delivered in medical/surgical units where an estimated 35 to 40 percent of unexpected hospital deaths occur, and where nurse turnover is the highest.

- As highly trained professionals regularly at patients' bedsides, nurses play a central role in ensuring the quality and safety of hospital care.
- Nurses can help lead efforts to reduce adverse events and unanticipated deaths, reduce harm from falls and improve reliability of evidence-based care.

The "Transforming Care at the Bedside" program empowers nurses and other front-line staff to redesign work processes to achieve better clinical outcomes in an effort to improve the quality of patient care and nursing staff retention.

- Nurses and other front-line staff including physicians, social workers, pharmacists, managers of various departments and other caregivers lead the improvement efforts within their institution to design, rapidly test and evaluate interventions to improve care. Innovations that show success are implemented throughout all medical/surgical units.
- Participating hospital units also seek to redesign processes to enhance the admission and discharge processes, improve handoffs, streamline documentation and optimize routine care processes.
- Participating organizations see a cultural transformation that leads to better clinical outcomes for patients, increased time in direct care, reduced turnover for nurses and reduced costs for the hospital overall.

Aligning Forces for Quality **offers a TCAB collaborative that will help empower nurses to lead efforts to improve the quality and safety of patient care in hospitals.**

- Funded by the Robert Wood Johnson Foundation and staffed by experts at The George Washington University, the TCAB Collaborative is an important part of the Foundation's strategy to improve quality in health care.
- The TCAB Collaborative will lead hospitals through a collaborative effort to systematically measure and enhance the quality of nursing care provided to their patients.
- The hospitals will participate in a "learning network" to test new ideas, quantify results and share lessons learned. Program successes will be shared nationwide throughout the four-and-a-half year initiative and potentially adopted at hospitals and medical centers across the country.

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