



A Tale of Three Practices: How Medical Groups are Improving the Patient Experience

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Introduction

Medical practices are facing increasing pressure to improve their patient experience survey scores. Forces contributing to this growing imperative include public reporting of CAHPS Clinician & Group (CG-CAHPS) survey scores through the Aligning Forces for Quality (AF4Q) program sponsored by the Robert Wood Johnson Foundation, public and private purchaser initiatives to build measures of the patient experience into performance-based payment programs, and the use of such measures in accreditation, certification, and recognition programs. A growing demand among patients for an enhanced service experience and greater participation in their health care is placing further pressure on medical practices to find ways to become more patient and family-centered.

As medical practices strive to improve their performance, the experience of others that have developed and implemented successful strategies can provide valuable guidance and lessons. This brief presents an account of how three practices in different parts of the country have achieved improvements in the following specific domains:

- Stillwater Medical Group in Minnesota, a multispecialty group practice that focused on improving a key aspect of doctor-patient communication;
- Westwood-Mansfield Pediatrics in Boston, a pediatrics and family practice that focused on improving access and health promotion; and
- A specialty surgical practice associated with a large, urban, academic medical center that focused on improving customer service and access.

While each practice is unique in its focus and approach, all generally follow the well-established Plan-Do-Study-Act (PDSA) improvement model by: (a) using patient experience survey data and other assessments to evaluate current performance and set an aim for improvement (PLAN); (b) developing a strategy to meet the aim and implementing the interventions (DO); (c) using data to monitor whether the change strategy has been effective (STUDY); and (d) learning from the process to refine the approach and make it more widespread and sustained (ACT). The case examples for each practice are organized according to this improvement cycle. The brief concludes with a summary of cross-cutting themes and lessons that are common across the three practices.

Stillwater Medical Group: Improving Communication with Patients

Background

As one of nine medical groups participating in Minnesota Community Measurement's 2008 statewide pilot to publicly report patient experience data, Stillwater Medical Group (SMG) made an early commitment to addressing this dimension of quality. Comprised of two clinic sites in eastern Minnesota and one in western Wisconsin, SMG now continually surveys its patients using the same CG-CAHPS tool used in the Minnesota statewide survey in order to identify areas for improvement and monitor the results. SMG's ongoing survey protocol generates 15 completed surveys per provider per quarter, which allows for a rolling average based on an aggregate of 60 survey returns annually.

Plan: Targeting After Visit Information

For its improvement efforts, SMG chose to target an aspect of doctor-patient communication measured by the survey item that asks patients if they received easy to understand instructions about taking care of their health problems or concerns. They arrived at this point of focus through conversations about what providers most wanted to improve and analyses showing which CG-CAHPS survey items

Stillwater Medical Group

Location:

Eastern Minnesota/Western Wisconsin

Practice Type:

Multispecialty

Number of physicians:

58 (plus 6 mid-level providers)

Website:

www.stillwatermedicalgroup.com

Contact:

Larry Morrissey, M.D., Medical Director
for Quality Improvement

correlated best with the question that asks patients to give an overall rating of their doctor.

By focusing on this particular question, SMG could also take advantage of coinciding delivery changes underway due to the medical group's implementation of a new electronic medical record (EMR) system. Use of the EMR's after visit summary (AVS) module was being emphasized in order to meet federal meaningful use objectives – a practice also likely to help patients feel they received helpful instructions on how to care for their health problem or condition. The AVS module allows the provider to print out a summary report that can be given to the patient to take home and which outlines all the issues addressed during the visit, test results, medication lists and important follow-up steps to take.

Do: Implementing the After Visit Summary (AVS)

SMG's Internal Medicine department adopted use of the AVS much more quickly than Family Medicine, allowing for a natural comparison. Prior to implementation of the medical group's EMR in May 2010, both departments were at a baseline of 0% AVS usage. Following implementation, Internal Medicine was using the AVS for an average of 51% of its patient visits, while Family Medicine was using it for only 6% of visits.

According to the SMG leadership, a key factor in Internal Medicine's more ready adoption of the AVS was positive modeling by a handful of physician champions within the department who were early adopters of the tool. One physician in particular—who also serves as president of the medical group—saw his own individual scores improve for the “received easy to understand instructions” survey item from 84% in the 4th quarter of 2009 to 100% a year later, corresponding to his increased usage of the AVS and eventual use of the tool with 100% of his patients. As the former chief medical information officer, this particular provider also had a high level of credibility in demonstrating the positive value of utilizing the EMR to its full extent. His dramatic improvement alerted the medical group to the powerful potential of the AVS and prompted deeper review which showed that other early adopters were showing significant progress as well. After seeing the positive results in the personal practices of these

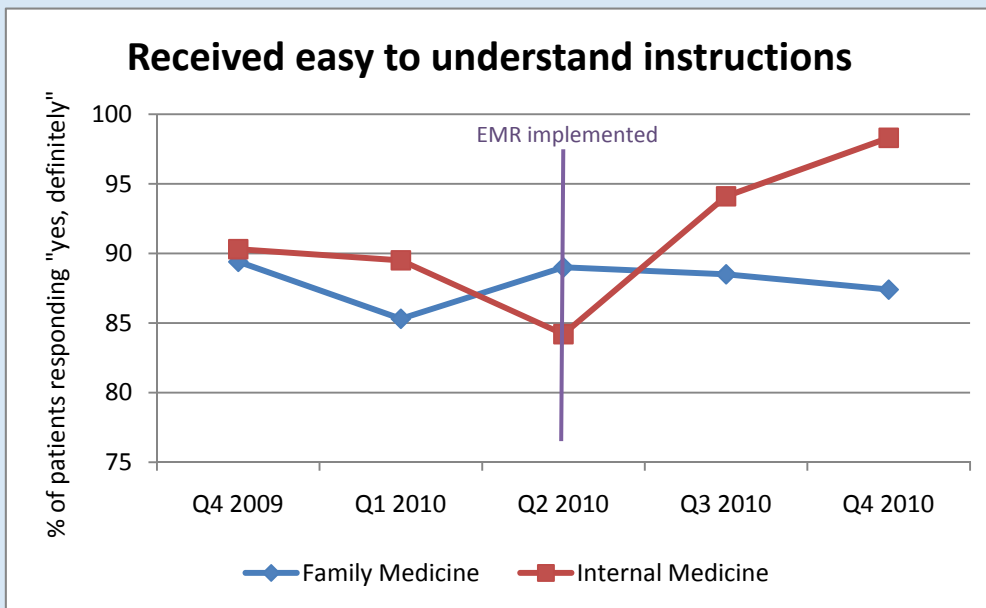
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physicians, SMG began sharing and promoting this experience of using the AVS across the organization.

Study: Tracking Improvements in Survey Scores

The results indicate that use of the AVS has had a positive impact on the number of patients reporting having received easy to understand information to take care of their health condition. While performance on this CG-CAHPS item stayed relatively steady for Family Medicine, results improved for Internal Medicine from a low of 84% to a high of 98% of patients saying they definitely received easy to understand instructions. This increase coincides with the department's adoption of the AVS tool available for use once SMG implemented its new EMR system (see Figure 1). Similarly, while the percentage of Family Medicine patients rating their doctor as a 9 or 10 on a 0-to-10 scale remained at 72% in both the 4th quarter of 2009 and a year later, Internal Medicine saw an increase of three percentage points (from 79% in Q4 2009 to 82% in Q4 2010).

Figure 1. Stillwater Medical Group results for an individual CG-CAHPS item showing improved performance for Internal Medicine after its adoption of the After Visit Summary (AVS) as part of the medical group's new EMR



Data source: Stillwater Medical Group

Act: Spreading the AVS to Other Departments

Stillwater Medical Group plans to use Internal Medicine's success with the AVS as an example to influence other departments to utilize the tool. One challenge is the response from some departments that they are simply under too many other pressures to take this on. But by normalizing this process as part of the patient visit, providers will also reap the benefit of reducing workload downstream, by decreasing the number of patients calling the office for follow-up information or needing to come back right away for another appointment.

This CG-CAHPS survey item is now part of SMG's compensation package, which should also help to drive usage of the AVS tool among the medical group's other departments.

Westwood-Mansfield Pediatric Associates: Promoting Patient Self Care to Improve Access

Background

Westwood-Mansfield Pediatric Associates (WMPA) cares for patients at its two practice sites located in the Massachusetts towns for which the practice is named. Both Westwood and Mansfield are situated in the southwest Boston area. The practice is part of the Pediatric Physicians' Organization at Children's Hospital Boston. WMPA has had its patient experience scores publicly reported since the first biennial statewide survey was conducted by Massachusetts Health Quality Partners (MHQP) in 2005 using the Ambulatory Care Experiences Survey (ACES) tool. The ACES is closely related in content to the later developed CG-CAHPS. The practice also monitors feedback from its patients more frequently through shorter, focused surveys sent electronically.

Plan: Targeting Health Promotion and Access

With its stated goal to be proactive in the care of children, Westwood-Mansfield Pediatric Associates set out to improve its patient experience, particularly in the areas of

Westwood-Mansfield Pediatric Associates

Location:

Boston Area, Massachusetts

Practice Type:

Pediatrics

Number of physicians:

8 (plus 8 nurse practitioners)

Website:

www.wmpeds.com

Contact:

Lester Hartman, M.D., Senior Associate

health promotion and access. The practice was deliberate in examining its MHQP statewide survey results from the perspective of which improvements it believed would bring the most value to its patient families. In these terms, WMPA sees the education and empowerment of parents as not only an approach for improving health promotion, but also something that can ultimately affect access to the clinic, by reducing unnecessary visits for health concerns parents can manage at home. Keeping an eye on the growing push toward global payments, WMPA was also motivated to strategically position itself to have greater capacity to address more complex, chronic diseases while minimizing the time spent on non-urgent, acute conditions.

In addition to reviewing its patient experience scores, the practice took stock of the most frequent health concerns driving its patient visits. What it found is common for most pediatric practices across the country: The number one reason for a clinic visit was a sore throat, with the concern that it could be due to a strep infection. This was followed by visits for ear infections, colds and fever. The time demand posed by the volume of these visits presented a challenge for the practice, which was eager to shift focus to more chronic and complex threats to child health, such as obesity.

Do: Teaching Parents How to Do a Strep Test at Home and Other Educational Outreach

As a result of its analyses, Westwood-Mansfield Pediatric Associates decided to undertake a pilot program to give parents the skills and equipment to conduct strep tests at home, with the knowledge that 65-75% of those tested for strep will be negative. The practice also posted educational videos on its website and YouTube addressing top health concerns for which parents most frequently called into the clinics. These included an [instructional video](#) on how to perform the at-home strep test. A third tactic involved the use of regularly emailed educational newsletters on timely health topics, as the practice had obtained email addresses for 90% of its patient families. As shown below, the combination of these three interventions, all aimed at providing patient families the necessary information to undertake more self-management of minor illnesses at home, led to a significant reduction in unnecessary medical visits.

WMPA credits its ability to undertake this innovative approach to improving health promotion and access to the leadership and coordination provided through an executive director position, a non-physician role dedicated to working with employees in a team-based way to tackle change.

In early 2009, WMPA mailed 2,000 free rapid strep test kits to parents of children aged 6-12. The mailing contained an [introductory letter](#) along with instructions of when and how to use the kit as well as how to interpret the results. Any positive results were then repeated in the clinic office and only upon confirmation were antibiotics prescribed. If tests were negative, parents were informed that their child did not need to present to the clinic as long as the sore throat and fever resolved in less than 48 hours. The home test proved popular with parents, both from the perspective of saved time and money as well as the ability to avoid having to come to the clinic and be exposed to other sick patients.

At the same time, WMPA focused on developing a new Obesity Management Program, with an emphasis on diagnosing obesity using body mass index (BMI) measurement and educating patient families on issues such as diet and physical activity. With 24% of its patients having a BMI above the 85th percentile, the practice soon saw that as appointment spots opened up from the reduction in strep throat visits they were quickly filled with patients coming in to address obesity concerns.

WMPA credits its ability to undertake this innovative approach to improving health promotion and access to the leadership and coordination provided through an executive director position, a non-physician role dedicated to working with employees in a team-based way to tackle change. The structural change to add this new position coincided with the results from the 2007 MHQP survey. The executive director worked with physician leaders to review the data and develop a strategy to improve.

Study: Tracking Improvement in Survey Scores, Patient Visits, and Email Communication

While patient experience surveys commonly address access in terms of how well a patient is able to reach the clinic by phone and get a timely appointment, Westwood-Mansfield Pediatric Associates' approach to access has involved helping parents to avoid the clinic for the acute condition of strep throat and instead increase access for chronic disease concerns, such as obesity. This may explain that while its access scores for the MHQP survey stayed constant between 2007 and 2009, its scores for health promotion rose from 3.5 to 4 stars between the two years (signifying a move from a standing above the 50th percentile in 2007 to a new standing at above the 85th percentile in 2009). The practice ranked 9th for health promotion among 169 pediatric practices measured by MHQP, but aims to be number 1 in the next round of reporting. WMPA also saw a gain from 3 to 4 stars in its patients' willingness to recommend the practice to others (see Figure 2).

WMPA believes it is addressing a concern that patient families value, that of savings in time and money for unnecessary trips to the clinic. As more and more costs shift to patients themselves, the practice aims to provide families the maximum value for their health care dollar. WMPA has seen consistent growth in its practice, which it attributes to its proactive approach. Surveys conducted specifically about the home strep test found 70% of patient families would always or almost always recommend doing the home strep test to a family member. For those parents who don't feel comfortable doing the test at home and prefer the doctor do so, the practice continues to encourage those families to come right in.

Comparing itself to another pediatric practice serving a similar panel of patients in the same time period to control for seasonal effects on the presence of strep, WMPA found a 28% reduction in its office visits for strep tests compared to an 8% reduction at the comparison site, a statistically significant difference. Meanwhile its visits for obesity management increased by 45% in the first three months of 2009 compared to the same time period the year before. Revenues collected for obesity management were 30% higher per visit than for visits due to strep throat. In essence, the practice has been able to shift focus to more pressing chronic disease concerns without experiencing an associated loss in revenue. Instead of patient visits dominated by acute issues, the practice now counts the chronic issues of asthma and obesity among its top four reasons for a clinic visit.

Figure 2. Westwood-Mansfield Pediatric Associates' improvement in patient experience scores following efforts to better engage patient families with health information and to specifically train parents in the use of an at-home strep test

<u>Select Measures</u>	<u>2007</u>	<u>2009</u>
Communication	★★★	★★★★
Health Promotion	★★★ ^{1/2}	★★★★
Organizational Access	★★	★★
Willingness to Recommend	★★★	★★★★

Key: ★★=Above 15th percentile; ★★★=Above 50th percentile; ★★★★=Above 85th percentile

Data source: Massachusetts Health Quality Partners

The practice has also seen shifts toward more electronic interaction with patients and is currently working to increase usage of its patient EMR portal and secure email system. WMPA has sent out over 200 emails to educate patient families on timely health concerns since it started to collect email addresses four years ago. Data show that patient families open these emails at a rate of 33-57%.

Act: Moving on to Improve Coordination and Continuity of Care

Westwood-Mansfield Pediatric Associates continues to give free step tests for patients ages 5-7 and sells an additional 1,000 tests per year. It has campaigned with the FDA and Walmart to encourage over-the-counter sale of the tests.

The practice plans to next tackle a different area of patient experience, namely the survey item which asks whether patient families believe the doctor has good knowledge of the patient, both from a medical history perspective as well as the patient as a person. Because WMPA's practice model does not emphasize patients seeing the same provider each time unless they have special needs and encourages a highly collaborative approach among its clinic staff—such as providers sharing a common space instead of individual offices and regularly discussing cases—it plans to utilize a function within its electronic medical record (EMR) called the “yellow sticky” which will always put essential information about the patient front-and-center as the provider reviews the patient's records. Efforts to populate this EMR tool with salient information about the patient, for instance if the child is afraid of needles or is a hockey star at school, is now underway as a tactic to help doctors and other clinic staff strike up conversation and better engage with their patients. The practice hopes it will see positive results from its efforts as it aims to increase its current 2-star standing for this measure.

A Surgical Practice: Improving Patient Service Through Staff Training and New Hiring

Background

The medical organization studied is a surgical practice specializing in liver disease and transplant surgery. The practice is one of several specialty practices affiliated with a large, urban, acute-care, academic medical center.

The following encapsulates an extensive case study on one practice's quality improvement intervention to improve patient experience. The full case study was produced by RAND Health for the Agency for Healthcare Research and Quality. “Improving Customer Service and Access in a Medical Practice” will be the third in a series of case studies produced by RAND Health available on the [CAHPS website](#).

Also affiliated with the medical center are a hospital and a faculty practice group—an association of physicians and the administrative organization that has responsibility for multiple specialty practices. The practice operates an ambulatory clinic specializing in liver disease and related conditions and provides both treatment and surgical interventions. In addition, as a result of a merger, this specialty practice also serves as a general surgery clinic and performs surgeries other than those related to the liver for approximately 45% of the patients it sees each year. Starting in May 2006, the faculty practice group began administrating the CG-CAHPS survey to patients of all of its primary care and specialty physicians.

Plan: Targeting Customer Service and Access

Beginning in 2006, upper management of the surgical specialty practice became aware of problems related to its customer service and access. These issues were brought to light based on patient complaints and management's observation of patient-staff interactions. The issues were then confirmed by reviewing data sources, including operations data generated by the medical center systems as well as patient experience data collected through CG-CAHPS surveys. Specialty practice scores for CAHPS items addressing customer service and access to care were below the faculty practice group average, confirming the suspected problems.

A consultant was brought in to further study the issues through an informal evaluation of the practice. Throughout this process, some of the problems uncovered included patients abandoning phone calls after being put too long on hold; patients experiencing long waits both to get in for an appointment and then again in the waiting room once there for a visit; doctors frequently canceling and rescheduling existing appointments; and staff treating patients and each other in a rude manner.

Through this internal review, the practice determined the problems in access and customer service were rooted in staffing issues. Staffing problems included both an inadequate number of skilled support staff to run the large and complicated practice as well as some clashes in work culture stemming from a recent merger with staff from another specialty practice. In addition, the practice determined staff were in need of further training in customer service and business operations.

Do: Addressing Staffing Issues

Improvement efforts were rolled out in two cycles taking place over several years. Beginning in early 2007, a series of training courses were offered to help staff interact with patients in a more positive manner. The trainings were accompanied by newly developed protocols and guidelines for actions such as answering phones and triaging

calls, which had previously been less defined. Content was developed to provide skill building for both general and management staff in customer service and business administration practices to improve practice operations. The specialty practice manager played a role in developing and testing courses such as *Connecting with Customers* and *Introduction to Appointment Scheduling*. Training courses were expanded in 2008 and 2009 to include new courses such as *Dealing with Difficult Patient Situations* and *Outpatient Encounter Registration*. Work schedules were adjusted to allow staff to take part in the trainings, and staff received recognition and incentives for participation. Eventually courses became mandatory.

In addition to training, staffing was adjusted to address workflow and management problems. Using the data collected, the practice manager was able to present a strong case to the chief administrative officer in the department of surgery that patient flow, service and volume were being severely hampered by insufficient staffing. Eventually the request made its way to hospital leadership which committed \$1M for the hiring and upgrading of staff. A new nurse manager role was introduced, with an RN filling the position to better oversee daily operations. The practice was also able to hire a second nurse manager as well as upgrade back office staff from hospital assistants to Licensed Vocational Nurses, who were better equipped to handle more complex patient needs. In addition, a few consistently low-performing staff were also let go.

Furthermore staff morale was addressed by establishing morning “huddles” (i.e., short morning meetings to update staff and encourage problem-solving), providing more face time and recognition from management, and introducing Christmas bonuses that included all staff.

Study: Tracking Improvement through Patient Complaints, Survey Scores and Operations Data

Both operations data and CAHPS survey data were used to set goals and monitor progress. In addition, patient complaints were reviewed in detail and patterns categorized to target specific performance problems. While, anecdotally, relationships between patients and staff seemed to be improving, it took nearly two years for operations and patient experience data to reflect these improvements.

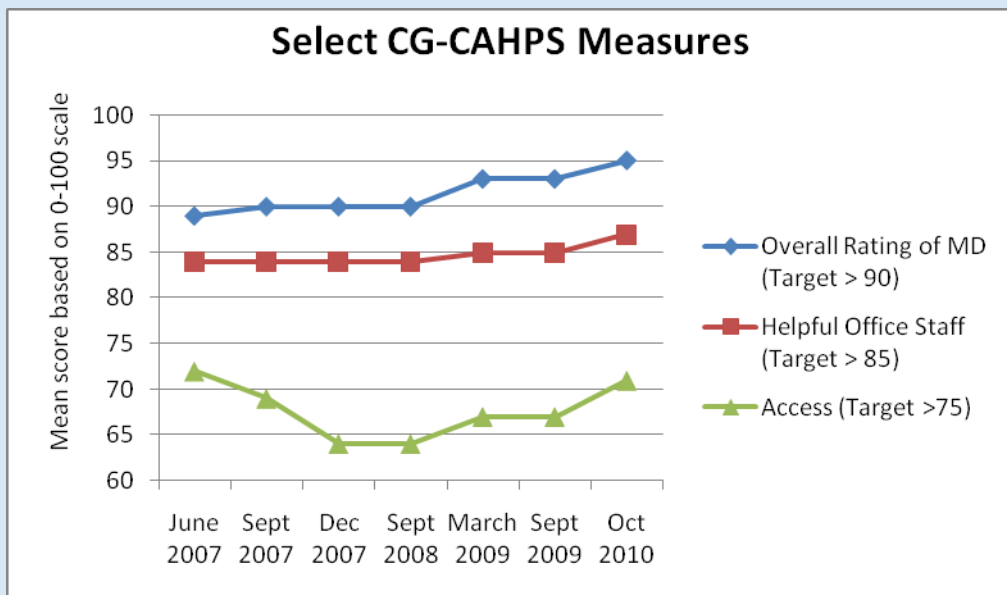
Operational data allowed the practice to monitor its new patient rate, call-abandonment rate, the rate at

While, anecdotally, relationships between patients and staff seemed to be improving, it took nearly two years for operations and patient experience data to reflect these improvements.

which physicians “bumped” patients (i.e., cancelled and rescheduled appointments), and its patient cancellation or “no show” rates. CG-CAHPS data of most interest included composite scores for access and helpful office staff, plus the overall rating of the doctor.

Targets were set for the metrics based on the average scores for the overall faculty practice group as of June 2007. By October 2010, the practice had met four of its seven access and customer service targets and made significant, incremental improvements in the other three measures. For instance, CG-CAHPS scores for the helpful office staff composite increased to 87 (based on a 0-100 mean score) from a baseline score of 84, meeting the target set of >85. The overall rating of the doctor score increased from 89 to 95, exceeding the target of >90. On the other hand, while the access composite inched up to 71 from previous lows of 64, it remained shy of the >75 target (see Fig. 3).

Figure 3. Specialty Practice CG-CAHPS results following interventions to address staffing issues



Data source: RAND Health

Act: Moving on to Improve Coordination and Continuity of Care

As of early 2010, the practice’s training courses remain ongoing and have become part of the assessment and hiring process. Performance data continue to be reviewed to

monitor for ongoing improvements as a result of the instituted changes. The current practice manager reports that when a problem trend arises it is addressed immediately with the staff member responsible using one-to-one feedback and modeling by more experienced staff. While most metrics were improving, some such as the CG-CAHPS access composite and the rate at which patients were “bumped” by their physician remain stubbornly below target, meaning that more work may be required to discourage physicians from cancelling and rescheduling appointments.

Meanwhile, the broader faculty practice group has begun developing efforts to improve communication with patients as measured by CG-CAHPS data. This emphasis has helped to support the practice manager by signaling a wider commitment to the goal of improving patient experience.

Cross-Cutting Themes

The growing recognition of patient experience as an important element of quality has created a strong imperative for medical practices to identify and implement interventions for achieving high levels of patient-centered care. Improvement efforts can range from a relatively small workflow change—as seen in Stillwater Medical Group’s adoption of an after visit summary (AVS) tool—to a larger scale change such as the staff restructuring witnessed in the final case study.

While the three practices highlighted here all shared a similar goal of improving service to their patients, each followed its own strategic path based on a careful analysis of patient experience measures and other factors unique to the practice. Although the specific focus and interventions differed, several cross-cutting themes can be identified as key factors contributing to the success of all three:

- 1. A combined micro- and macro-level approach:** Improving patient experience requires both a focus on micro-level changes (e.g., introducing an AVS tool; providing free strep tests to patients; instituting staff training) at the point of care delivery as well as the macro-level changes (e.g., changing normative practice in communicating with patients; shifting practice focus from acute to chronic care; overhauling the skill-level of staff) that address the overall organizational culture, which supports and ultimately sustains a fundamental transformation of the patient experience.

2. **The indispensable role of leadership:** All three practices similarly credit the critical role of leadership support to provide the credibility, coordination and resources required to make these changes successful and sustainable. At Westwood-Mansfield Pediatric Associates, for example, a new executive director position was key in organizing support to pilot an innovative approach to health promotion and access through the distribution of at-home strep tests.
3. **A need for patient survey data:** The use of a reliable and consistent source of patient experience data is fundamental to multiple phases of the improvement effort. However, it is important to note that in most cases data are not exhaustive and are best used in conjunction with other types of assessment, including those producing qualitative information. An example of this can be seen in the final case study, in which patient complaints and staff observation alerted management to issues with patient experience. Survey data helped to corroborate the existence of a problem. Survey data were then integral in setting targeted goals and monitoring progress in achieving them. They were also essential in communicating the extent of the problems to staff responsible for the improvement and leadership called upon for support.
4. **Alignment with other organizational goals:** Efforts to improve the patient experience can often be perceived as an unnecessary added burden to managers and front-line staff that feel overwhelmed by the demands of a busy clinical practice. While the [business case](#) to invest in patient experience can be persuasive on its own merits, additional efforts to tie patient experience improvement to other broader organizational aims can go a long way in building support for the initiative. In each case study, the approach to improving patient experience capitalized on the current milieu and goals of the practice:

Resources for Improving Patient Experience

- The CAHPS User Network offers several resources to support the use of CAHPS surveys for quality improvement:
 - The [CAHPS Improvement Guide](#) offers a comprehensive presentation of improving the patient experience in a searchable web-based publication.
 - Other improvement [resources](#) such as project summaries, reports and library of audio and video resources.
- The [Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital](#) provides references for numerous tools and curriculum, including a listing of resources categorized by survey composite topics.
- The [California Quality Collaborative](#) offers a rich catalog of resources in improving patient experience, including the [CQC Guide to Improving the Patient Experience](#).

whether taking advantage of new technologies to meet Federal guidelines; getting out ahead of changing trends in payment structures and focusing resources on emerging health challenges; or situating the practice to facilitate greater business growth and reputation. Each improvement effort sought a way to integrate the focus on patient experience as a key part of the overall organizational drive toward excellence.

The results of standardized patient experience surveys such as CG-CAHPS clearly show that medical practices have abundant opportunities for improving the patient experience. The case examples provided by the three practices profiled in this brief offer a compelling vision of how these opportunities can be effectively addressed to create a more optimal experience for patients and practices alike.

About the Author:

Shaller Consulting Group, led by Dale Shaller, provides technical assistance to Aligning Forces for Quality by helping regional alliances support patient experience measurement and improvement. This paper was prepared by Michelle Ferrari. The author would like to acknowledge and thank the following people for sharing their story:

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in Communities Across America



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