OUTPATIENT QUALITY, ACCOUNTABILITY, AND MEASUREMENT PLANNING MEETING:

LEVERAGING OUR ASSETS TO FORGE ALIGNMENT AND ACTION

THE ROBERT WOOD JOHNSON FOUNDATION AND THE COMMONWEALTH FUND

Outpatient Quality, Accountability, and Measurement Planning Meeting: Leveraging Our Assets to Forge Alignment and Action

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MEETING SUMMARY

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Introduction and Background

Growing evidence of serious deficiencies in the quality of health care in the United States has galvanized support for efforts to measure and improve the quality of care.[1] While there is emerging consensus on a common set of quality measures for inpatient settings, less attention has been given to measuring and reporting on the quality of outpatient care.[2] Since the majority of medical care is provided in physicians' offices and other ambulatory settings, the quality of this care is critical to the performance of the health system as a whole.[3]

This report summarizes a meeting of stakeholders convened by the Robert Wood Johnson Foundation, in cooperation with the Commonwealth Fund, to discover common interests and plan ways of accelerating outpatient care quality improvement and accountability for the prevention and management of chronic disease. This report covers meeting objectives, the process by which the meeting was conducted, a synthesis of work plans developed by breakout groups representing each of the stakeholder groups, and highlights of expert observations on themes and ideas for aligned action. Each of the work group plans is summarized in separate reports; the appendix presents a side-by-side comparison of the plans.

Meeting Objectives

Prior to the meeting, interviews were conducted by Robert Wood Johnson Foundation staff and by Amy Brinn and Barry Dorn of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health, with a representative set of anticipated participants to obtain expectations for the agenda and observations on outpatient quality improvement. Interviewees expressed a common sense of urgency for the need to integrate diverse efforts in the field and align stakeholder goals and strategies so as to achieve consensus on a roadmap for moving forward.

Based on this input, the following meeting objectives were determined:

1. To learn and share information on current work to advance development, understanding, and use of outpatient measures to improve health care quality.

2. To create an aligned approach for the development and use of outpatient measurement to drive quality improvement among the many organizations and researchers involved in these efforts.

3. To lay the groundwork for an ongoing structure to improve the coordination and effectiveness of research, development, and demonstrations aimed at improving outpatient quality.

Meeting Process

The meeting was moderated by Leonard Marcus and Barry Dorn of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health. Marcus and Dorn introduced participants to their multi-dimensional problem solving process known as *The Walk*

in the Woods. This framework served as a method both for conducting the meeting and for thinking about how to address the issue as a whole.

The *Walk in the Woods* method is designed to generate integrated agreement among stakeholders as they move through a four-stage process of renegotiating working relationships, from:

1. ***self-interest*** (describing one's own needs) to
2. ***enlarged interests*** (discovering shared interests), to
3. ***enlightened interests*** (working together to craft new options), to
4. ***aligned interests*** (establishing a mutually satisfying partnership).

Several meeting participants were invited to present on the current state of the art and practice in outpatient quality measurement, improvement, and accountability. The moderators led meeting participants in a discussion of each presentation. Following these presentations, participants were assigned to six breakout working groups for a joint exercise to chart logical next steps, priorities, and methods for accelerating progress.
The premise for the working group exercise was that progress will require an intentional step-wise, evolutionary process involving two key dimensions:

- ***Technical factors***: These are key knowledge gaps and practice barriers to overcome, such as what will be measured, how the scientific adequacy of measures can be assured and improved, how the data will be acquired and reported, and the most effective strategies for using measures to improve quality and/or accountability.

- ***Stakeholder factors***: Different constituencies, representing a variety of interests and objectives on matters of quality measurement and accountability, differ on how these technical matters should be handled or overcome. An underlying assumption is that none of the stakeholders have or could have the ability to address these gaps and barriers on their own, and none of them wield outright authority over the process. Therefore, recognizing and resolving these differences is an important part of the work to advance the field.

Each working group was assigned to represent one of six stakeholder or constituency groups on matters of quality measurement and accountability (groups were composed of individuals representing the particular stakeholder as well as persons from other stakeholder groups):

Stakeholder Group	***Definition***
Purchasers	Public agencies such as the federal Centers for Medicare and Medicaid Services (CMS), private insurers, and large employers
Consumers	Individuals and advocacy representatives of consumer interests
Providers	Clinicians, health care organizations, and their representative organizations
Quality Improvement	Accrediting bodies and organizations that collect, use, and report on

Organizations (QIOs)	quality measures
Researchers	Independent investigators and those linked to stakeholder groups
Funders	Private and public supporters of investigation and demonstrations

Working groups were charged with applying the *Walk in the Woods* methodology to examine the problem from the perspectives of these different stakeholders, analyzing their distinct interests, the translation of those distinct interests into different technical solutions, and the opportunities and the obstacles presented by these different perspectives. The goal of these deliberations was to plan (from the perspective of their particular stakeholder) a conference or series of meetings and actions to accelerate progress on outpatient quality improvement over the next 6 to 12 months, with an eye toward refining practices over the next 2 to 5 years.

On the last day of the meeting, the working groups presented their plans to meeting participants. Following presentations by the working groups, a panel of experts identified overarching themes across the work group plans and opportunities for action. One individual from each group was commissioned to prepare a report summarizing that group's assessment and plan.

Summary and Synthesis of Stakeholder Working Group Plans

Please see the appendix for a detailed, side-by-side comparison of the working groups reports, including the following topics describing each group's assessment and plan:

- ***Aim(s)*** of the working group plan and ***rationale*** for the recommended approach.

- ***Ambulatory care quality measurement goals*** – what each working group most wanted to see in regard to the development, selection, standardization and use of outpatient quality measures, including recommendations or consensus about what categories of measures most need to be measured and reported.

- ***Areas of convergence among stakeholders*** – the opportunities for moving forward where agreement is likely to be found among stakeholder interests.

- ***Barriers to action*** – each group's assessment of the chief barriers to reaching the goal of outpatient care measures that would be valid, reliable, standardized, fair, reported, affordable, and useful. Barriers were of two types: those associated with divergence in stakeholder interests, and technical barriers in knowledge, data, or systems.

- ***Ideas for aligned action*** – each group's plan for translating areas of convergence into action and for overcoming barriers to action.

- ***Action steps*** – specific, immediate steps to implement the plan.

The following sections present a narrative synthesis comparing and contrasting the workgroup plans along several of these dimensions. This analysis identifies both common and divergent themes so as to highlight opportunities for progress and areas where further work is needed to overcome barriers. Since a negotiation among stakeholders would be required to determine the actual intersection of their interests, this synthesis does not represent a true combination of the plans or a "finished product" of the meeting.

Note: descriptions of stakeholders' interests or intentions refer to the working groups' assessments of these factors, which may differ from stakeholders' actual interests or intentions.

Overview of Working Group Plans

The workgroups' proposed approaches are rooted in the unique stakeholder perspectives that they were directed to represent in approaching the problem and its solution *(please see the work group reports for a more detailed explanation of the plans)*. Each group was composed of individuals who took the hypothetical position and perspective of a particular stakeholder group.

Stakeholder Group	Summary of Plan	Main Ideas for Action
Purchasers	Convene a national goal-setting summit to galvanize agreement on a "moon-shot" approach to solve technical problems and create transformational change in two key performance areas that would build momentum for systems change.	Unified market intervention by purchasers, data pooling for public reporting, community demonstrations, and Presidential endorsement.
Consumers	Educate and ensure active participation of consumers so that consumer wants and needs are understood as a central factor in efforts to measure and improve quality.	A series of summits, a public relations campaign, and financial and technical support for consumer advocates to participate in measurement planning and implementation.
Providers	Establish local learning collaborations to catalyze a culture change whereby all members of the health care team participate in quality improvement and share a common goal for improving ambulatory care quality.	Goals and direction would be given though a national planning process and local healthcare community stakeholders with the support of specialty boards and local medical/specialty societies.
Quality Improvement Organizations (QIOs)	QIOs would agree on a common set of performance measures, a standardized (possibly centralized) data collection process, and a shared measurement database with a user-specific interface.	Mutual agreement among QIOs to enforce this "one-system" approach so that all stakeholders would eventually adopt a single measurement and data set for accreditation, improvement, choice, and research.
Researchers	Establish a new research agenda to better understand the incentives and barriers that influence the adoption and use of performance measurement.	Capture the attention of stakeholders so as to direct more effective, efficient, and broad-based applications of performance measurement.
Funders	Collaborative effort among funding organizations to establish a national goal to measure outpatient quality across the entire continuum of care using multi-dimensional measures.	Establish a framework linking measurement with improvement, sponsor demonstrations of rapid-cycle process improvements, and identify models for information dissemination.

Measurement Goals and Plans

- ***Purposes***: The broadest conceptualization of measurement encompasses three purposes: accountability, choice, and improvement; these goals are inherent in several workgroup plans. All workgroups described the use of measurement to improve quality, which appears to be the primary purpose for providers. Those in the funders work group in particular, wanted to ascertain the mechanisms by which this linkage occurs. Those taking the perspective of Purchasers and Consumers focused on the role of public reporting of performance measures. Those in the Providers work group acknowledged accountability as a shared principle, perhaps to be realized as a function of stakeholders' involvement in local collaborations and/or reporting on their progress.

- ***Scope:*** Work groups representing the interests of Consumers, QIOs, and Funders wished to establish a comprehensive measurement approach that would address the total scope of patients' experiences with outpatient care. Designated "consumers" also wanted broader information to improve self-care and help them navigate the system, and designated "funders" hoped to address patients' social support needs. Those representing the perspectives of Purchasers and Providers, on the other hand, wanted to focus on a limited number of measurement goals at the outset. These differences are not irreconcilable, however, if stakeholders were to agree to a step-wise approach for implementing a comprehensive vision a few measures at a time.

- ***Unit of reporting***: In addition to system-level performance measures, work groups representing Consumers and QIOs described physician- or provider-specific measurement as important for purposes of accountability and choice. Based on their stated goals, it seems reasonable to assume that "purchasers'" and "funders'" work plans would encompass, or at least not be incongruent with, physician- or provider-specific measurement. Providers also may require provider-specific measures for purposes of confidential performance feedback.

- ***Types of measures***: Designated Funders wished to establish and promote multi-dimensional measures of outpatient quality that cut across disease and age categories. The QIO work group also proposed measures that cut across the continuum of care. These types of generic measures may not fully meet the needs of providers (for directing improvement actions toward specific goals) or Consumers (for disease-specific measures of provider expertise)but do get at key dimensions of care coordination. Designated Purchasers envisioned disease-specific measures of population health, such as for diabetes. One conclusion: reconciling stakeholders' objectives may require implementing both generic and disease-specific measures of quality.

Areas of Convergence Among Stakeholders

Each workgroup identified several areas ("sweet spots") where stakeholder interests are likely to converge. Identifying benefits that are likely to be shared through measurement can help build momentum for overcoming stakeholder-related barriers. Likewise, identifying common objectives for measurement targets and methods can lead to solutions for overcoming technical barriers.

Given the wide variety of topics identified by workgroups, this analysis focuses on topics likely to gain broad acceptance among stakeholder groups. Specifically, this means topics mentioned by one or more workgroups (sometimes in different ways) that appeared to be congruent with other workgroup plans or that were not described as barriers to others' plans.

***Shared goals and benefits of measurement**:*

- improving patient outcomes and population health,
- engaging consumers in self-management,
- establishing the business case for quality,
- providing information for more intelligent choices,
- empowering stakeholders through participation and collaboration, and
- realizing efficiencies or cost-savings.

***Shared interests for measurement methods**:*

- establishing national standards to ensure that measures are trustworthy and fair,
- defining a common measurement set that can be used efficiently by all stakeholders,
- limiting measures to the minimum number to accomplish objectives,
- ensuring that measures are easy to understand and use, and
- implementing an improved information infrastructure to more efficiently and effectively collect data for measurement and improvement.

Barriers to Action

The workgroups identified a variety of stakeholder-related barriers to reaching consensus on performance measurement goals for outpatient quality of care, along with a few technical barriers. The groups generally did not evaluate the severity of barriers to achieving action. For the purpose of this analysis, it is assumed that any barrier mentioned by a workgroup is of potential concern to aligned interests, while a topic that is mentioned by several workgroups indicates a barrier of potentially greater concern.

- ***Differences in stakeholder priorities***: Four workgroups noted that different stakeholders may have potentially conflicting priorities for the use of quality data (see below). The purchasers workgroup noted divergence between its conviction that the nation must set ambitious national goals to drive transformational change and a perception that providers' prefer more incremental steps toward improvement. Providers noted the lack of an established culture to facilitate meaningful interaction among stakeholders.

- ***Questions about costs and incentives***: Four workgroups noted concerns about who will pay the costs of infrastructure improvements, measurement standardization and implementation, and improvement (the business case for quality). Two groups noted market disincentives for standardized reporting if rank-and-file customers demand customized approaches—which points out the need to involve all stakeholders (widely and deeply) in seeking agreement for national quality measurement and reporting goals.

- ***Lack of information infrastructure***: Four workgroups noted the technical barrier posed by cumbersome data collection due to the fragmented and immature nature of the national information infrastructure (and the need for an electronic health record to achieve timely and efficient data collection). Other technical barriers that were mentioned include a lack of validated measures across all quality domains and inadequate techniques for case- and risk-adjustment to ensure fairness of comparative measurement.

- ***Disagreement on readiness for accountability***: Three workgroups noted a divergence between purchasers' and consumers' desire for public reporting of performance information as a means to drive system change, and providers' opposition to public reporting due to inadequate risk-adjustment (a technical barrier). In general, providers do not believe that public reporting should be the driving force for quality improvement. Researchers also noted the need to determine the locus of accountability for addressing social and behavioral issues.

- ***General resistance to change***: Two workgroups noted that performance measurement may be associated with time hassles, disruptions in the current state of affairs, and fear of market dislocations that could lead some stakeholders to favor the status quo.

- ***Uncertainty about stakeholder role efficacy***: Two workgroups noted that uncertainly about whether key stakeholders—in particular, consumers—would fulfill the role that is presumed to be necessary for performance measurement to achieve its potential, and the potential for conflict if consumers are not well educated. Funders also noted that their levers of influence and imperatives for involvement are diverse and complex.

Ideas for Aligned Action

Despite the appearance of divergence among these approaches and the barriers to action noted above, there are several promising areas where the work plans offer synergies and potential for aligning interests and harmonizing performance measures and measurement strategies. *(see table on page 4)*. The exercise appeared to help participants discover enlarged (shared) interests and craft options that represent movement toward enlightened interests. For example, almost all groups envision a process for reaching out to other stakeholders to receive input and invite participation in their chosen approach.

While each group's plan is driven primarily by that particular stakeholder's own activities and influence—such as purchasing power, consumer activism, professional and community accountability, regulatory enforcement, knowledge generation, and funding influence—these interests are not necessarily divergent. Looking across the plans, each appears to represent an "intentionally fitted" piece of a puzzle that is more likely to be successfully assembled to achieve a comprehensive solution. Many plans envision further negotiations among stakeholders that could lead to more fully aligned interests in practice.

- ***Empowering consumers***: If consumers become activated, they could play a "bridging" role to encourage greater alignment of interests among stakeholders towards the threefold goals of accountability, choice, and improvement. Consumers have wider interests than simply exercising choice. In many cases, consumers do not have effective choice of provider, or they

may not wish to disrupt an established relationship with a trusted clinician. Hence, they may wish to use information to partner with their clinician to seek improvement in their own care and the care of others like themselves. Activating consumers to take greater responsibility for self-care also offers promise for improving the quality and outcomes of care.[4] For this approach to succeed, consumers must be educated to understand what quality means and to have realistic expectations of what quality improvement can accomplish.

- ***Community collaboration for improvement***: The Providers' work group plan for community learning collaborations would fit well with Purchasers' work group plan for community demonstrations. Moreover, such collaboration could play an important role in helping to educate and involve consumers as stakeholders in the process. Both "Purchasers and Providers" envisioned a "short list" of measurement goals, differing only in how these goals are selected (national uniformity versus a combination of national and local goals). Providers' choice of measures could incorporate the national goal-setting process envisioned by purchasers. Linking these community collaborations into a national network of community stakeholders could create a grassroots movement to advocate for quality improvement nationally.

- ***Constructive use of performance information***: How purchasers and health plans use performance information is important to the success of quality measurement. Using performance information to narrow health care provider networks, and thus to constrain consumer choice, may achieve rapid results but alienate both consumers and providers. Giving consumers education, information, and incentives to make more informed choices may be a more sustainable path to system change, although perhaps slower and less certain.

- ***Responsive regulation***: If QIOs participate as active partners with other stakeholders in developing the measurement standards to be used in public reporting and community collaborations, they would likely gain greater buy-in for their mission and realize the goal of "regulation for improvement" than by attempting to impose standards through external enforcement alone.[5] This involvement also would help ensure that accreditation and public reporting are congruent with envisioned national and local priority-setting processes.

- ***Supportive actors***: Researchers and funders can play a critical role in support of these efforts through funding, evaluating, and disseminating the results of demonstrations and models for collaborative action that will link measurement to improvement. Involving other stakeholders in determining the funding and research agenda can help ensure that efforts are creative, relevant, and usable to those who are responsible for implementing and replicating the results.

Considered together, the groups' measurement goals would address the *Two Pathways to Quality Improvement,* as elucidated by Berwick and colleagues.[6] These pathways are: 1) selection of caregivers based on quality outcomes, and 2) improvement in quality outcomes through changes in the processes of care. As Berwick and colleagues note, many measures can be useful for both accountability or selection and improvement. Moreover, selection is not a discrete concept but can encompass continuous variables such as reward, recognition, or payment incentives.

Major issues are in need of resolution include:

1. The role of public reporting—what measures can satisfy the goal of empowering consumers while also meeting the concern of fairness to providers?
2. The scope of measurement—should a comprehensive measurement approach be undertaken, or should efforts focus on a few areas to build momentum and success?
3. Incentives—how should costs be born and how can incentives be aligned to promote development of a supportive information infrastructure and a business case for quality?

Observations of the Reactor Panel

Following are highlights of observations by a panel of experts that identified overarching themes across the work group plans and opportunities for action.

Paul Schyve, MD, Senior Vice President, JCAHO, identified:

Three potential "levers" for action:
1. purchasing power,
2. the business case for quality, and
3. regulation.

Three imperatives for convening an effective stakeholder meeting:
1. a convener,
2. funding, and
3. the business case for participation.

Three key factors to establishing a sustaining structure:
1. linking measures to choice, accountability, and improvement,
2. establishing the electronic health record (or updating the insurance claim form) to integrate data for quality measurement, and
3. research.

Finally, Dr. Schyve recommended starting with users' needs, particularly standardization, and optimizing many groups' interests rather than maximizing a single group's interest.

Judith Hibbard, DrPh, Professor, University of Oregon, compared and contrasted the interests of the three principal stakeholders as follows:

Consumers	Providers	Purchasers
Want to reduce complexity	Want consumers to appreciate the complexity	Want alignment and use of quality measurement
Want to identify good providers	Some want to be highly ranked; some don't want to be ranked at all	
Want to trust and partner with their providers to use and understand quality information	Fear undermining trust	

Dr. Hibbard proposed that breaking the current "circle of unaccountability" will require that consumers begin to care about quality, that empowered consumers could make the difference to achieving the responsive, high-quality health care system envisioned by experts. Currently, however, consumers' assumption that medicine is already evidence-based leads to a lack of demand for quality measurement. Hence, creating consumer ownership and demand for quality requires focusing on reporting as well as measurement.

Steve Wetzell, Strategic Director, Consumer-Purchaser Disclosure Project, proposed that creating a roadmap to measurement will require:

1. leadership and vision,
2. role definition, and
3. urgency and timeline.

A strategy for action must include:

1. convening those who can "broker the deal" to make it happen,
2. fully funding the National Quality Forum (NQF) to achieve its role,
3. giving authority to implement the plan, and
4. education and readiness of purchasers, consumers, and brokers to "put their money where their mouth is."

John Lumpkin, MD, Vice President, Robert Wood Johnson Foundation, noted the basic underpinnings of quality measurement and improvement rest on:

Data + Analysis = Information

and

Information + Rules = Knowledge

Hence, each interaction with the health care system is a chance for knowledge generation using electronic technology. A National Health Information Infrastructure could provide decisional support for consumers and clinicians to speed knowledge transfer.

Other observations:

- Quality measurement is only one tool for improvement; it's all we have now, but it doesn't hit every nail since not all things can be measured.

- Efforts to promote public reporting must address the current "culture of blame" which is the real issue behind providers' resistance to provider-specific reporting.

- Achieving "Six Sigma" is not about achieving perfect outcomes, but avoiding errors; it is possible to achieve given enough time.

Finally, Dr. Lumpkin noted several common ideas for achieving action:

1. consumers activated and working together (however, consumers may not want to think about the "guts" of what they expect to happen to keep them safe and healthy),
2. community-based collaborative initiatives to change the culture,
3. funders working together, and
4. much greater harmonizing or alignment in measurement and reporting requirements .

Conclusion

This meeting offered a promising platform for understanding how stakeholders' interests might be better aligned for action and the barriers that must be addressed to achieve a national strategy for outpatient quality measurement and improvement. Both the process and the outcomes of the meeting should prove useful for this purpose.

- Following a problem-solving process of seeking to understand other stakeholders' interests, working groups were able to develop enlightened interests and devise action plans that hold promise for achieving cooperative actions for system change. By convening stakeholders to negotiate aligned interests and seek a culture of cooperation, quality measurement and improvement is more likely to take root and thrive.

- The outcome of the meeting provides a potential roadmap for advancing the field through a combination of activities including national goal setting, definition of a standard measurement set, consumer empowerment, community collaboration, a new research agenda, and potential collaboration among funders. Issues for resolution include the role of public reporting, the scope of measurement, and the means of aligning incentives.

The reactor panel noted that leadership, funding, and a sense of urgency are needed to translate this experience into a concrete action leading to sustained progress.

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