

# **Aligning Forces for Quality: The Regional Market Project**

First Annual Meeting and  
Consumer Engagement  
Learning Community Meeting

June 26–29, 2007



Robert Wood Johnson Foundation

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The first annual grantee meeting for *Aligning Forces for Quality: The Regional Market Project* (AF4Q), a Robert Wood Johnson Foundation national program, took place in Seattle, Washington on June 26–28, 2007. Subtitled *Healthy Markets, Healthy People: Accelerating Change*, the meeting for the first time brought together representatives from each of the 14 communities participating in AF4Q, for two days of learning and discussion about the work accomplished so far and the work ahead over the next few years as these communities take on the challenge of improving the quality of health care for their residents with chronic illnesses.

The AF4Q annual meeting was immediately followed on June 29 by a one-day meeting of the Consumer Engagement Learning Community that focused specifically on questions and strategies around the involvement of consumers in each community's quality improvement work.

Staff from the Center for Health Improvement, the national program office for AF4Q, designed and chaired both meetings. **Attachment A** lists the communities participating in AF4Q.

This paper summarizes the key themes from each meeting, highlighting the issues grantees are facing, and can expect to face—and the resources and assistance they will have available—as they work on the components of the AF4Q program.

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**Background: The National Program**

The AF4Q national program seeks to build a body of knowledge about how local market forces can work together to drive and sustain improved outcomes for the chronically ill. To this end, the 14 participating communities are each working to align the efforts of health care providers (physicians/physician groups, nurses, clinics), health care purchasers (employers and insurers) and health care consumers (patients) to improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression and heart disease. The hypothesis of the national program is that this alignment—of understanding, of intent and of the actions that result—will lead to higher quality care, healthier residents and healthier communities.

Specifically, each community participating in AF4Q is working on:

- *Public reporting*: efforts to provide accurate information about physician and physician group performance that can be used by consumers, purchasers and providers to drive improvement.
- *Quality improvement*: efforts to develop a sustainable community-wide capability to help providers improve the community's ambulatory and chronic illness care quality.
- *Consumer engagement*: efforts to help consumers take an active role in their own care and in the improvement of chronic illness care in their communities.

Communities began their work in early 2007; the program will continue for three years.

### Key Themes

The agenda (see [Attachment B](#)) of the AF4Q Annual Grantee meeting addressed each of the three components of the program, with presentations and discussion on such topics as:

- Federal actions that support public reporting of quality information and quality improvement.
- National efforts to advance performance measurement, public reporting and quality improvement.
- Strategies for promoting culture change in physician communities.
- Examples of collaboration among insurers, employers and providers to improve quality.
- Methods for engaging consumers as truly equal partners in quality improvement work.

Throughout the presentations, and especially in the subsequent discussions, three key issues emerged:

First, the meeting's participants struggled with the need to balance the requirements for perfectly realizing each of AF4Q's components (public reporting, quality improvement and consumer engagement) with what they felt their communities could, in fact, achieve in the course of the grant period: how could they **effectively manage the tension between the perfect and the good?**

Second—not surprisingly, given the overall purpose of AF4Q—participants raised many **issues around collaboration and alignment**: across economic sectors, within and between communities, and among the teams from each of the AF4Q communities.

Finally, participants debated the role of **information as a way to secure commitment to the goal of improved patient care**, questioning and advising on the types of information that would be most useful, and how best to present this information to make it most accessible to those who need it.

(The meeting also included several presentations on technical assistance that will be available to the AF4Q grantee communities. These presentations are summarized in [Appendix 1](#).)

### Managing the Tension Between the Perfect and the Good

#### **For Public Reporting**

The accuracy, reliability and utility of the information on physician performance promulgated by the AF4Q communities is essential to the underlying goal of the program. In this situation, the perfect and the good must be seen as almost synonymous. But presentations by some of the AF4Q faculty stressed the very real difficulty in achieving this perfection. RAND's Elizabeth A. McGlynn, Ph.D., in particular, spoke of the difficulties of reporting information about the *community-wide* performance of physicians, as opposed to performance within a given health plan. Aggregating physician data across collecting entities is fraught with pitfalls, affecting even such seemingly simple data elements as physician identifiers and specialties. The National Committee on Quality Assurance's Joachim Roski, Ph.D.,

M.P.H., seconded McGlynn's points, reminding communities that actions they take to resolve these problems (e.g., requiring a physician to see a certain number of cases before his or her performance is reported) will have consequences (e.g., limiting the number of physicians whose performance then can, in fact, be reported).

Ultimately, however, just such tradeoffs will need to be made, and each community will need to come together to “weigh the options,” as Roski put it, against the “chances of being wrong.” While warning participants that this is “not the easiest of discussions,” he added that decisions about such factors as sample size, confidence intervals and ways that patient characteristics are accounted for can be very helpful in bridging the gap between perfection and what is achievable within the parameters of the AF4Q program.

As overall guidance, and in response to a participant asking for a definition of the “gold standard, vs. the silver standard, vs. the bronze standard” in performance reporting, McGlynn added general advice: “The tradeoffs (you make) are determined by how you will *use* the information. The strategies that have been most effective,” she continued, “are the ones that engage physicians in a dialogue. Change happens by getting attention, and by people working together on solutions. We don't want to impede this, or set it back.”

### **For Quality Improvement**

In the AF4Q program, the information provided through the public reporting of performance data is meant to inform consumers and also to become the basis of quality improvement by physicians. The annual meeting's first day included several presentations on physician-based quality improvement efforts, and these presentations also explored the tension between the perfect and the good in this use of performance data.

In his presentation, Tom Simmer, M.D., of Blue Cross and Blue Shield of Michigan, described a program of value partnerships in which the insurer worked with 35 physician groups, providing financial incentives to the groups whose member physicians showed improvement on measures of evidence-based care for chronic illness, as well as ancillary activities such as increased prescribing of generic drugs and increased referral to the insurer's care management services.

Simmer stressed two points in describing how the quality of care is measured:

- First, the data are self-reported, and come from registries that each physician group creates for its patients seeking chronic illness care. These registries then become tools both for clinicians, in their management of each patient (as they tell a clinician, for example, when a diabetic patient last had a retinal exam), and for insurers who use data aggregated from the registries to assess the quality of care offered by physician groups.
- Second, Blue Cross and Blue Shield of Michigan has determined its incentive payments based on, as Simmer said, “the degree to which improvement has taken place.” The insurers' focus on improvement over time, rather than a one-time snapshot of performance levels, means that data must be comparable over time within a given physician group, and the precision of comparisons across groups becomes less critical.

The key role of registries, and the attitude they support towards improvement, was emphasized also by Ed Wagner, M.D., M.P.H., director of the McColl Institute

for Healthcare Innovation at the Group Health Cooperative, who presented his observations at the end of the annual meeting's first day. Registries are an inherent part of the chronic care model,<sup>1</sup> developed by Wagner and his colleagues as a framework for the improvement of chronic illness care. The chronic care model, Wagner said, "is really all about having *enough* information technology, so you can identify your patients and be reminded of evidence-based practices."

### **For Consumer Engagement**

Thinking about engaging consumers in the use of performance information adds further complexity to the balance between the perfect and the good.

Several of the presentations on data reporting led to discussions about the specifics of performance measures: what level of blood sugar should be acceptable for diabetics, for example. While the experts spoke of the challenges in defining intermediate outcome measures, they also stressed, again in the words of Elizabeth McGlynn, the importance of "how consumers can *use* this, too." An HbA1c level of 7, or 6, or 8 will not be likely to have much meaning to the average health care consumer.

Consumers, in fact, have a high tolerance for imprecision in physician performance ratings, reported Arnold Milstein, M.D., M.P.H., chief physician for Mercer Health and Benefits and medical director of the Pacific Business Group on Health, citing research<sup>2</sup> that shows that almost a third of consumers would tolerate physician performance ratings that range from 20 percent to 50 percent inaccurate.

Milstein went on to sum up the overall challenge highlighted by the discussions around this theme at the Annual meeting. Providers, he noted, have a much higher threshold of minimum validity than consumers. The choice of who will determine validity is, he said, a "pivotal decision" in making the comparative efficiency of health care providers generally transparent. While Milstein was speaking specifically about efficiency, the same pivotal decision will also affect each of the AF4Q communities as it carries out its health improvement work.

## **Collaboration and Alignment**

### **For Public Reporting**

The concepts of alignment and of effective collaboration are critically important in the public reporting of quality data, which currently is a field full of players, uses, measures, and priorities. "We need one measurement system!" emphasized Ed Wagner in his summary of the first day of the meeting. And several speakers highlighted specific ways in which the concepts of alignment and collaboration need to be considered by the AF4Q program's communities.

First, the AF4Q communities should watch for, and be prepared to capitalize on, a number of national efforts that will support their work. Mark McClellan, M.D., visiting senior fellow at the AEI-Brookings Joint Center and former administrator for the Centers for Medicare and Medicaid Services (CMS) spoke specifically of national efforts that will seek to improve the interoperability of existing databases, through what McClelland referred to as a "distributed data approach." Under this approach, which has been endorsed by the AQA (an alliance of major stakeholders

<sup>1</sup> [http://www.improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

<sup>2</sup> Davis, Hibbard and Milstein, "Consumer Tolerance for Inaccuracy in Physician Performance Ratings: One Size Fits None," Center for Studying Health System Change IB, 110, March 27, 2007.

in the arena of health care quality),<sup>3</sup> improved sharing of information about the structure of data sets and efforts to regularize their components and rules, will make it easier to aggregate information. McClellan has every expectation that this approach will prove useful to national, regional and community-level alliances.

Carolyn Clancy, M.D., the director of the Agency for Healthcare Research and Quality (AHRQ), described AHRQ's plans for Chartered Value Exchanges that will, among many other things, provide a proving ground for this distributed data approach. Some of the proposed exchanges—those with a strong track record—will be able to pool their data with Medicare data to get a much more accurate picture of physician performance.

Questions of alignment and collaboration also affect AF4Q grantees as they struggle with the question of whether there are disparities in health care quality among different sub-populations in their communities. Ed Wagner, in his day 1 summary, reminded participants that “Quality is disparities is quality. Quality improvement must include attention to eliminating disparities, and eliminating disparities is quality improvement.” Speaker Helen Burstin, M.D., M.P.H., of the National Quality Forum, reminded grantees to think about how to assess the existence of disparities “now, rather than later.” She presented a set of principles to use to select disparities-sensitive measures, consisting of:

- The prevalence of the condition in the minority population.
- The impact of the condition; whether and how it affects the minority population.
- The potential impact of work to improve quality on the minority population.
- The size of the “quality gap” between the minority and majority populations.

### **For Quality Improvement**

Several of the speakers at the annual meeting described successful quality improvement initiatives that were anchored in collaborations among stakeholders in the health care system.

- Robert Mecklenburgh, M.D., chief of medicine at Seattle's Virginia Mason Medical Center; and Kelley Hardin, director of benefits for Starbucks described an effort in which Virginia Mason's re-design (in collaboration with Starbucks) of treatment for back pain in Starbuck's employees—to a process that moved patients quickly to physical therapy rather than spending a lot of time on diagnostic services—was matched by Starbuck's willingness to change its payment practices, “aligning reimbursement with value,” as the speakers described it, so the new treatment process was economically sustainable for Virginia Mason.
- In his explanation of community-wide projects to improve diabetes care and breast medicine, Alan Glaseroff, M.D., chief medical officer for the Humboldt Del Norte IPA and a member of the team from AF4Q grantee Humboldt County, California displayed a sociogram of the work of this community, showing the intersections of the different sectors of the health care system (consumers, clinicians, hospitals, the government, and employers) with the specific players (e.g., the IPA, the county's safety net clinics, advance practice clinicians and reference labs) and each entity's involvement in the projects underway: the various patient registries, a health education alliance focused on

<sup>3</sup> The AQA Alliance's principles governing data sharing and aggregation can be found at <http://www.aqaalliance.org/files/Data.AggPrinciples-May06.doc>

building self-management skills, a breast medicine Web site, a specialty referral conference, and others. The lines of this sociogram cut across the page in all directions; Glaseroff described results including the elimination of disparities in care of diabetes patients in the community and a ten percentage point increase in one year in the annual mammogram rate for eligible women.

- Thomas Lee, M.D., of Partners Healthcare System in Boston, presented the Bridges to Excellence initiative as a pay-for-performance system that directly seeks to align reimbursement with quality improvement and stresses collaboration across stakeholders. Physician practices are rewarded with enhanced payments based on improvements in diabetes, cardiac and spine care and for the implementation office systems designed to reduce error. Bridges to Excellence helps purchasers of health services and providers structure these reward mechanisms in such a way that both entities share the rewards (enhanced payment for providers, reduced health care costs for purchasers) and also provides methods and tools for patients to use to become more actively involved with their care.
- Dinner speaker Doug Kight, J.D., of Boeing, spoke of his organization's successful adoption of the principles of lean production, stressing the absolute necessity of alignment and collaboration in this effort. He used the example of Toyota, which has, in his words, "the hearts and minds of all in the process devoted to continuous improvement."

Ed Wagner drew on these examples and reminded the AF4Q grantees of the importance of a community-focused infrastructure to support quality improvement. Among the components of this infrastructure are guidelines (and consensus on them), a method for learning about how to do quality improvement work, and community support for patients as they work on their own management of their chronic condition.

### ***For Consumer Engagement***

Many presenters stressed the need for efforts related to alignment and collaboration to ensure the engagement of consumers in quality improvement work.

First, the different parts of the health care delivery system are not currently in accord on the role of and for consumers. Debra Ness, M.S, executive director of the National Partnership for Women and Families, noted that viewing consumers as equal partners—that such collaboration and alignment should be a goal—is a real culture shift for many in health care. Step 1, she continued, therefore becomes helping stakeholders to believe that consumers should, in fact, be such collaborators. She stressed the value of including consumer advocacy organizations in the conversation about consumer engagement, noting that their knowledge of their constituencies and their track record as trusted sources of information makes them particularly useful in the task of building coalitions. Dawn Simonson, M.P.A., executive director of the Minneapolis-St. Paul Metropolitan Area Agency on Aging, agreed: "Don't limit who you think good advocates can be," she said.

Second, significant barriers exist to alignment and collaboration around consumer engagement. In her talk, Ness observed that the information that will most effectively engage consumers (for example, physician rankings) is likely to make the other stakeholders (e.g., physicians) the most uncomfortable. Donald Storey, M.D., senior medical director of the insurer Aetna provided one example of

presenting such information, Aetna's Site of Service Price Transparency Tool, warning participants however of the importance of communicating constantly with providers about such efforts while also seeking to integrate a consumer-centered approach and principles of collaboration into the information's development and use.

Third, presenting information alone is not enough to engage consumers. Michael Cropp, M.D., president and CEO of Independent Health and Board Chair of AF4Q grantee the P<sup>2</sup> Collaborative of Western New York, described the collaborative's "Target the Heart" community campaign, which initially focused on raising awareness of the levels of heart disease and incidence of stroke among women in the region. Creating the call to action was good, Cropp explained, but "we needed a pathway to move forward," to build on and sustain the momentum generated through an effective information campaign.

Finally, consumers and consumer groups also need to think about collaboration with other sectors and new areas in which they should be working. Susan Prows, Ph.D., M.P.H., who has visited all the AF4Q sites, reminded participants that getting consumers engaged in improving their own health is not the job of health care providers only, but is rather the entire communities' responsibility.

At one point, AHRQ Director Clancy reminded the meeting, "We are all consumers." This comment provides a guidepost to how to bring the concepts of collaboration and alignment to the task of consumer engagement. At their core, the divisions among the players in health care delivery are artificial. We are in most ways all in this together.

## **The Role of Information in Securing Commitment to the Goal of Improved Patient Care**

### ***For Public Reporting***

The purpose of the public reporting component of the AF4Q program is to give consumers the information they need to choose high-quality (and perhaps high-value) providers, and to give providers the information they need to improve. Each is equally important. The expert faculty at the AF4Q annual meeting repeatedly reminded grantees that, to be effective, this information must be carefully gathered and presented. Their second observation was that potential unintended consequences of the ready availability of performance data can be managed through attention and foresight.

Any consumer presented with performance data needs to be able to see how "what I do makes a difference," as AHRQ's Carolyn Clancy described it. "Posting (the data) isn't enough," she noted, adding that more thought needs to be given as to whether the target audience should be all consumers or a key subset of them. In her presentation Clancy showed an example of a speedometer-like meter that simply and clearly displayed Washington State's health care performance in both a current and baseline year, as compared to other states. Clancy noted that this analogy was particularly useful in presenting performance data to policy-makers and legislators.

Other speakers highlighted the anxieties that physicians and other providers may have about the public reporting of information on their performance. John McDonough, Ph.D., executive director of Health Care for All in Massachusetts,

who provided summary comments at the end of the meeting's second day, took exception to the metaphor of using patients, armed with performance information, as weapons against physicians. He stressed that this would be counterproductive: "Don't look at it as a duality, look at it as a continuum," he advised. "Aim for the sweet spot in the middle; challenge where appropriate, but understand the role of the physician as partner (in the improvement effort)."

As for the fear that the public reporting of information about performance will give physicians a tool to use against patients, guiding physicians to select healthier or more compliant patients to ensure that their performance scores remain high, Partners Health Care's Thomas Lee was reassuring. "Everyone talks about this but I don't see it happening," Lee observed. "Dumping patients is a hassle, it's easier just to take good care of them. Professionalism is the check on any perverse financial incentive."

### **For Quality Improvement**

Improvement cannot occur without measurement, all the meeting's presenters agreed. But measurement that exists to drive improvement has a different cast to it than measurement that exists solely for selection or judgment. Several speakers addressed the importance of the AF4Q communities' ensuring that the focus of the use of information remains improvement, and not criticism or judgment.

Bruce Bagley, M.D., medical director of the American Academy of Family Physicians, reminded the grantees that physicians may approach measurement with great trepidation. First, they are likely to make an initial assessment of quality based on what Bagley called "pedigree"—where a physician was trained, with whom he or she had published. They may view the data collection effort as onerous (especially when clinical rather than billing records are the source), and have doubts about the usefulness of many existing performance measures. And physicians may focus on outliers: the difficulty of eliminating, for example, the most noncompliant patient, rather than understanding that improvement consists of moving the mean performance forward.

How to cope with this outlook? Humboldt County's Glaseroff stressed the importance of physicians, whom he described as a "beleaguered workforce," having a belief that the quality of the care they offer *can* improve. "We ask doctors to describe a perfect day—your patients did what you asked, you had all the information you needed—and we ask, 'What's getting in the way of that?'" Glaseroff explained. The improvement work "has to be done by inviting them in and saying, this can help."

Ed Wagner reminded the grantees of the need to engage providers. "But can we (engage them)," he asked, "if we or some of our stakeholders do draconian things with these measures? The technical details are overwhelming, but can be tackled through collaboration."

### **For Consumer Engagement**

The message about the use of information to engage consumers that came through again and again throughout the meeting was the value of telling stories—and the importance of using trusted story tellers.

Several presenters told personal stories:

- Meeting keynote speaker and King County (WA) executive Ron Sims used his experience being part of a rope team climbing Mount Rainier as a metaphor for the community-wide collaboration required to improve health care.
  - Sims' presentation led the Puget Sound Health Alliance's Executive Director Margaret Stanley, M.H.A., to comment on the value of having a charismatic leader for a community coalition. "If you don't have one in your coalition," she advised, "you may want to go find one."
- RWJF senior vice president John Lumpkin, M.D., M.P.H., spoke of his father's experience with Alzheimer's Disease to highlight the challenges faced by users of the health care delivery system, and by their families.
- AHRQ director Carolyn Clancy used her own health care experience to describe a consumer's difficulty in obtaining clear information about health care costs. She added, "We need to bring the consequences of poor quality out of the realm of statistical work into stories of real people, whom we care about."

Others spoke more generally of the importance of stories. The Puget Sound Health Alliance's Diane Giese began the second day of the meeting with a reminder to participants of the key difference between "telling something about what you're doing," and "presenting information in a way that gets people to commit." A related theme was the importance of keeping the information clear and easily understood. Eve Gardner, executive director of AF4Q grantee the Healthy York (PA) Network, spoke of the need to develop an "elevator message," the basics that people should know, and RWJF senior communications officer Minna Jung, J.D., spoke of the necessity, when working in a field "full of jargon," of focusing on simple core principles: we care about quality, we care about making it better, and we care about taking this path together. And speakers also emphasized thinking about who will be telling the story: Debra Ness of the National Partnership for Children and Families reminded participants to "use a trusted messenger" to communicate necessary information. Peers should talk to peers, they will be the true advocates.

Health Care for All's John McDonough reminded participants of the importance of sharing information about access to care, and of thinking about the linkages that exist between access and quality. As the Center for Health Improvement's Patricia E. Powers, M.P.P.A., noted, consumer groups now are focusing on access; if consumer groups can also see the importance of issues around quality, there will be a new avenue and ally in the job of engaging consumers.

A number of tools are available to help with gathering and disseminating information that will engage consumers:

- AHRQ, with the help of the Advertising Council, has developed a patient involvement advertising campaign, *Questions are the Answer*, with Web site support that helps patients design ways to seek information from their providers.
- Provider members of the Puget Sound Health Alliance use health risk assessments to help consumers understand and address their health status.
- Grantees expressed a great deal of interest in learning more about the chronic disease self-management model developed by Kate Lorig of Stanford University<sup>4</sup>.

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<sup>4</sup> Lorig, Kate, "Chronic Disease Self-Management," *American Behavioral Scientist*, Vol. 39, No. 6, 676-683 (1996).

Most important, the AF4Q's Consumer Engagement Learning Community faculty chair Judith Hibbard, Dr.P.H., M.P.H., of the University of Oregon, introduced the concept of patient activation. The goal of the consumer engagement component of AF4Q is that patients who make informed choices about the health care they seek, and who actively participate in their own health through strong preventive behaviors and collaboration with their providers, can play an important role in improving health care quality. Sharing information is not enough to bring about this "patient activation;" Hibbard's research has shown that activation is what she called "a development process," and these "consumeristic" behaviors don't begin until the process is well along. About 40 percent of the population, Hibbard said, are at the low end of activation.

What does this mean for the AF4Q communities? Hibbard advised them to, first, measure the levels of activation among the different residents of their communities, and then to begin to segment their market, and target their information, by level of activation. "When patients are told to take actions they are not capable of," Hibbard warned, "they are more likely to do nothing." Identifying and working with the most highly activated patients allows them to become role models and mentors of the others, and creates a body of stories to be shared throughout the grantee communities.

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## **The Consumer Engagement Learning Community Meeting**

### **Introduction**

The purpose of the one-day CELC meeting, held immediately following the annual meeting, was to give participants from the grantee communities the opportunity to work with each other and with the CELC faculty ([Attachment C](#)) to refine their plans for this aspect of the AF4Q program.

CELC faculty chair Judith Hibbard opened the meeting with—appropriately—a story, of her attempt to conduct research on the reactions to be expected, from both physicians and consumers, when the latter sought to discuss quality information during a physician office visit. Hibbard described how she hired actors to portray such scenarios, and discovered that "the actors couldn't figure it out, it was so far out of their experience—and they had a script! Even things that are ordinary to us," she cautioned, "won't be ordinary to others." Through AF4Q, communities should seek to create an environment "where these behaviors are imaginable, visible, and people feel supported to do them."

### **The Process**

To begin to accomplish this goal, the CELC faculty designed a highly interactive day, starting with a breakout session in which groups of three or four grantee communities shared their visions, initial plans and expected challenges with each other. Two additional breakout sessions examined, first, the concept of consumers' choosing high-performing providers and, second, strategies concerning consumers' self-management of their health and health care. Finally, each grantee community had time to caucus and plan, and to report-out to the rest of the CELC.

## The Results

**Attachment D** presents the content<sup>5</sup> of the end-of-day report-out, when each community was asked to give:

- One idea they heard that they are considering adapting for their community.
- One topic that they would like to learn more about.

The ideas and topics fell into four general categories:

- Getting better at understanding consumers.
- Consumers' having more information about their own health (and the role of technology in supporting this).
- Strengthening clinical self-management.
- Engaging marginalized communities: Medicaid recipients, minorities and the uninsured.

### **Getting Better at Understanding Consumers**

Members of the Seattle AF4Q team caught CELC participants' attention with their statement that "Consumers *are* engaged, they're leading their lives," and that the real question is, "how can we get them to engage in effective care?" To this end, participants expressed interest in strategies to better understand how consumers act about their health, and how they feel about health care. They want to learn more about measuring patient activation, as Judith Hibbard described (see page 10), and also discussed:

- Listening tours, focus groups and other strategies to hear the consumer's voice.
- Measures of the patient's experience.

Listening tours came up as a way to ensure that efforts to engage consumers are not too "top-down," a concern related to comments during the annual meeting about ensuring that information for consumers comes from a trusted source. Participants presented listening tours as a way to start to build "grass-roots community social networks" in which consumers can truly be partners.

Other strategies to learn from consumers include:

- Minnesota conducted focus groups to learn about consumers' attitudes towards quality in health care, and Maine discussed plans for doing the same.
- York reported plans to interview 1,000 patients with chronic illness about their attitudes towards both their disease and their providers.
- Memphis described its assessment tool, "Your Health Journey," which asks questions like "what are you passionate about?" or "what drains your spirit?" Memphis team members reported that consumers appreciate being asked about who they are, rather than being categorized as a set of symptoms.
- Cincinnati intends to draw on the marketing expertise of coalition member Procter & Gamble's Consumer Health Institute for help in understanding consumer motivations.

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<sup>5</sup> Representatives from Detroit, MI needed to leave the meeting before the report-out, therefore their conclusions are not included.

Several sites asked if their colleagues had tried to measure the patient's experience. Detroit is exploring the possibility of adding questions around consumer engagement to the Consumer Assessment of Health Plans (CAHPS) survey, although other participants questioned whether any survey could provide information that would be helpful to identify actions to increase consumer engagement. Minnesota team members were interested in measuring the patients' experience to be able to engage with providers to improve their "soft skills" in dealing with patients, an important aspect of health care quality from the consumer's perspective.

### **Consumers' Having Information About Their Own Health**

"Consumers," one participant said during the day, "need information on their *own* performance. Then the consumer can engage the provider in a conversation." The discussion on this concept highlighted several strategies, including:

- Collecting the information, primarily through the use of health risk assessments.
- Giving the consumer access to the information, primarily through personal health records (PHRs).

Seattle team members described their use of health risk assessments to promote healthy nutrition and increased physical activity, and thereby combat obesity. These assessments have value both for the individual, who can get a profile of his or her own health status, and for the community, who can use aggregated assessment information to identify health issues and set priorities. Maine team members reported conducting health risk assessments also. Participants suggested that Cleveland explore using this tool as a way of beginning to make consumers aware of what quality care is.

Sites using PHRs include:

- Western New York, which is conducting a 6-month pilot test in which 400 patients will keep PHRs, either on paper or on a flash drive.
- Humboldt County, where PHRs have been made available to migrant farm workers, who are especially in need of carrying their health information with them.
- Maine supports the use of PHRs as part of their consumer engagement strategy, "know your numbers."
- In Western Michigan, a Web-based PHR supports the incentive strategies used by a local employer in its wellness program.

And, in a related discussion, participants from Cleveland said that the prevalence of electronic medical records in their community was one of the strengths supporting their quality improvement work.

Participants asked for more information about the use of PHRs to engage consumers (raising concerns around the possible growth of proprietary PHRs that could not be shared across a community).

### ***Strengthening Clinical Self-Management***

One member of Kansas City’s project team described how the team is working to send the message that “when we go see a doctor, we’re not wasting his time. Get a pad and bring questions!” Strategies for clinical self-management that intrigued CELC participants were:

- Kate Lorig of Stanford’s chronic disease self-management model (see p. 9, above).
- Motivational interviewing, especially as a skill for physicians to learn.
- Active support for patients as they navigate through the health care delivery system.

Although the Lorig model was not discussed widely during the day’s breakout sessions, it was the idea most often cited by sites when they presented their interests and needs at the end of the day. Sites were tremendously pleased that such a tested tool, so well matched to their AF4Q work, existed.

Humboldt County and Minnesota both described teaching providers to do motivational interviewing as a way of engaging with consumers to examine attitudes towards self-care and develop strategies for better self-care.

Memphis and Humboldt County were two sites that had created buddy systems, with trained patient navigators helping patients across the continuum of care. In a related strategy, Kansas City makes sure that chronic disease patients know about, and are able to use, guidelines for self-care.

### ***Engaging Marginalized Communities***

The team from Humboldt County described their interest in “going after the groups that are the hardest to reach,” because “if you can reach the struggling 20 percent that are outside of the system...the rest will follow.” Several sites expressed great interest in working with these marginalized communities, although most had not yet refined their specific strategies for doing so.

- Wisconsin is focusing its AF4Q program specifically on the Medicaid population. “A lot is going on in the business community to engage consumers.” one team member said. “Medicaid is where the need is.” Medicaid enrollees have a sense of their power, the team member continued, but wondered whether the providers in the state “are ready for engaged consumers.” The team will be working especially on the Medicaid enrollment process as a way to strengthen alignment among sectors in the payment and delivery systems.
- In Maine, the Medicaid program sees itself as a health plan, and “wants to play with the other health plans.” It is therefore an active part of Maine’s AF4Q coalition.
- Memphis still struggles with how to involve representatives of TennCare, the state’s managed Medicaid program.
- Kansas City, in its REACH program, works actively to engage minority communities, especially non-English speaking groups. Team members stressed that the community coalition “needs to look like the community.”

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**Summary**

Participants in AF4Q gathered with a willingness to share information and to learn from each other. Throughout the annual meeting and the CELC day that followed, grantees, faculty members, Center for Health Improvement staff and RWJF representatives grappled with the tension between what would be absolutely perfect and what would be perfectly good enough, and who decides where the perfect and the good meet; worked through the necessary components of collaboration and the necessary elements of strategic alignment; and brainstormed about the most effective ways to use information to improve the health of their communities.

Michael Painter, M.D., J.D., RWJF senior program officer and the instigator of AF4Q, started the meeting with a story of his own, one that described his vision for the future of the health care system: where information about quality is readily available, providers embrace the goal of quality improvement, consumers are engaged with their health and with working with their clinicians, and the community works together to align incentives to make this happen. At the end of the meeting, Painter praised participants for their “focused, intense, optimistic, clear-eyed commitment to being ongoing and better partners” as the work of AF4Q continues, and this vision becomes more real.

**AF4Q's Technical Assistance Resources**

AF4Q's first annual grantee meeting also provided a chance for grantees to learn about the many types of technical assistance they have available, and to meet the faculty that will be working with them on the program over the next three years.

- Helen Burstin, M.D., M.P.H., of the National Quality Forum, Elizabeth McGlynn, Ph.D., of RAND and Joachim Roski, Ph.D., M.P.H. of NCQA, in addition to presenting on the evolution of physician-level performance measures (as described above) spoke of the work their organizations will be doing with communities in the fields of performance measurement and public reporting. The grantee sites have been clustered based on their level of experience with, and readiness for, public reporting of physician performance information; the advisers will be working with each grantee cluster as well as holding webinars on specific measurement topics and sharing the most recent research in the field.
- Evaluation is a critically important element of RWJF's grantmaking strategy, as it is through evaluation that the new knowledge developed during programs like AF4Q gets quantified and disseminated. Laura Leviton, Ph.D, senior program officer at RWJF, and Dennis Scanlon, Ph.D., of Pennsylvania State University and principal investigator for the evaluation of AF4Q, described this aspect of the program, stressing that the purpose of the evaluation is learning and developing an evidence base for other communities to use if they adopt such collaborations to improve quality in the future.
- As meeting participants discussed, the way the work of AF4Q is communicated will play a key role in engaging consumers—and other stakeholders—in the work of the program. RWJF Senior Communications Officer Minna Jung, J.D., and Patrick McCabe, Partner of GYMR, LLC, a communications firm working with the Foundation, spoke of the resources that will be available to grantees. RWJF is working with its communications advisers to develop and test messages around health care quality that will resonate with consumers; there are plans also to develop a pool of materials for sites to use and share, and to provide targeted technical assistance around the specific needs of one or two grantees.
- The Consumer Engagement Learning Community (CELC) will be the major source of technical assistance on this aspect of AF4Q. The University of Oregon's Judith Hibbard, Dr.P.H., M.P.H., in her presentation on day 2 of the annual meeting, gave an overview of the CELC. Its work, she explained, will focus on capacity building: laying a foundation for working effectively on consumer engagement with all a community's stakeholders, and also supporting grantees as they work to build the capacity of the people in their communities to manage their own health and health care. The CELC Meeting held immediately following the annual meeting focused in more detail on the technical assistance needs and interests of the AF4Q communities in the work of engaging consumers.
- In addition to the technical assistance available to all grantees, the AF4Q program also offers annual mini-grants for which grantee communities can apply. These mini-grants, which are expected to average \$25,000, are designed to allow a community to get specific assistance to support its AF4Q work. Applications are due in early September, 2007 and successful applicants will be notified in mid-October.

Also at the AF4Q Annual Meeting, John Lumpkin, M.D., M.P.H., RWJF senior vice president, with his colleague, RWJF Senior Program Officer and Quality/Equality Team Leader Anne Weiss, M.P.P., provided context for AF4Q with a description of the Foundation's regional quality strategy. RWJF intends that this strategy will enable the participating regions to achieve, over the next eight years, long-lasting, fundamental and sustainable improvements in health and health care. Lumpkin and Weiss invited AF4Q grantees to think about the possibility of expanding their focus to tackle additional parts of the care continuum, with possible further support from RWJF, and become fuller partners in this regional quality strategy.

1. Cincinnati, OH
2. Cleveland, OH
3. Detroit, MI
4. Humboldt County, CA
5. Kansas City, MO
6. Maine
7. Memphis, TN
8. Minneapolis-St. Paul, MN
9. Seattle, WA
10. Willamette Valley, OR
11. Wisconsin
12. Western Michigan
13. Western New York
14. York, PA

**Meeting Agendas****Annual Meeting Agenda****Tuesday, June 26, 2007**

6:00–8:00 pm Reception

**Wednesday, June 27, 2007**

7:00–8:00 am Registration & Continental Breakfast

8:00–8:30 am Welcome and Conference Preview

8:30–9:10 am Robert Wood Johnson Foundation Update

9:10–10:10 am National Drivers of Change: What They Mean for Your Community

10:10–10:30 am Coffee Break

10:30–11:20 am The Evolution of Physician Level Performance Measures

11:25–12:15 pm First Steps in Publicly Reporting Efficiency and Price

12:15–1:30 pm Lunch

1:30–2:15 pm Roadtrip USA–Around the Communities in 24 Hours

2:15–3:15 pm Quality Improvement Breakout Sessions

3:15–3:30 pm Physical Activity Break

3:30–4:30 pm Evaluation: Benefits for Your Community

4:30–5:00 pm Commentator Observations: Key Learnings from the Day

6:00–8:00 pm Dinner

**Thursday, June 28, 2007**

7:30–8:15 am Continental Breakfast & Roadtrip USA–Around the Communities in 24 Hours

8:15–8:30 am Welcome

8:30–9:30 am Communications Overview

9:30–10:30 am Consumer Engagement Learning Community Overview

10:30–10:50 am Coffee Break

10:50–11:50 am Inclusion: Consumers as Equal Partners

11:50–1:15 pm Lunch

1:15–2:15 pm Successful Examples of Mobilizing Consumers

2:15–2:45 pm Commentator Observations: Key Learnings from the Day

2:45–3:00 pm Closing Comments

## **Consumer Engagement Learning Community Meeting Agenda**

### **June 29, 2007**

7:00–8:00 a.m.	Registration & Continental Breakfast
8:00–8:30 a.m.	Welcome & Introduction
8:30–9:45 a.m.	Anyregion, USA Consumer Engagement Scenario
9:45–10:00 a.m.	Break
10:00–11:00 a.m.	Community Cluster Feedback
11:00–12:00 p.m.	Breakout Sessions: Consumers Choosing High Performing Providers/Groups
12:00–1:00 p.m.	Lunch
1:00–2:00 p.m.	Breakout Sessions: Self-Management
2:00–2:15 p.m.	Break
2:15–3:00 p.m.	Community Planning
3:00–4:00 p.m.	Closing & Next Steps

**Consumer Engagement Learning Community Faculty**

David Ahern, Ph.D., Executive Director, Health e-Technologies

Meg Gaines, J.D., L.L.M., Director, Center for Patient Partnerships

Michael Goldstein, M.D., Associate Director, Institute for Healthcare Communication

Judith Hibbard, Dr.P.H., M.P.H., University of Oregon

John McDonough, Ph.D., Executive Director, Health Care for All

Arnold Milstein, M.D., Medical Director, Pacific Business Group on Health

Michael Parkinson, M.D., Executive Vice-President, Lumenos

Susan Prows, Ph.D., M.P.H., University of Oregon

Jennifer Sweeney, Program Director, Americans for Quality Health Care

## Attachment D

### Reports from the Aligning Forces for Quality Grantee Sites End of the Consumer Engagement Learning Community Day

Site	Ideas They Liked	Content They Wanted
Cincinnati, OH	<ul style="list-style-type: none"> <li>■ K. Lorig Self-management tool</li> <li>■ Peers educating peers</li> </ul>	Training on the Lorig tool
Western MI	Willamette Valley's shared messaging diagram	Assistance and research support on what the key messages are, especially for specific sub-populations
Kansas City, MO	Extra \$, and knowing what others are doing	Network of technical assistance, especially to help raise involvement by minority populations
Willamette Valley, WI	What Wisconsin is doing to work with Medicaid	Lorig tool, especially how it could be used online, as this could be a way to reach teenagers and young adults
Humboldt County, CA	Lorig tool (will augment their peer-to-peer model)	<ul style="list-style-type: none"> <li>■ Consumer rebellion: wants to learn how to reach the disenfranchised. Those who make unwise decisions often the hardest to reach.</li> <li>■ Economic disparities</li> <li>■ Options for the uninsured</li> </ul>
Maine	Listening tours: wants to learn how to do well.	<ul style="list-style-type: none"> <li>■ Motivational interviewing. Wants to teach providers and peer-to-peer counselors; other setting too. Wants to integrate into the culture.</li> </ul>
York, PA	Same as above	<ul style="list-style-type: none"> <li>■ Strategies for getting employers beyond a bottom-line focus (e.g., productivity models)</li> <li>■ Motivational interviewing for M.D.s</li> </ul>
Cleveland, OH	<ul style="list-style-type: none"> <li>■ Patient Activation concepts</li> <li>■ What MN has done</li> </ul>	<ul style="list-style-type: none"> <li>■ Best practices on measurement tools</li> <li>■ Consumer involvement in Web site design</li> </ul>
Seattle, WA	Reminder of importance of consumers as equal partners	<ul style="list-style-type: none"> <li>■ Measurement and evaluation tools "so we can prove our value"</li> </ul>
Memphis, TN	Idea of engaging patient and patient's accountability—getting patients to commit	<ul style="list-style-type: none"> <li>■ Patient navigation and navigation assistance on the community level (not just within a specific component of the health care system)</li> </ul>
Western NY	Lorig tool	<ul style="list-style-type: none"> <li>■ Social marketing</li> </ul>
Minneapolis-St. Paul, MN	"Aha" moment from Seattle's starting assumption that the consumer <i>is already</i> engaged	<ul style="list-style-type: none"> <li>■ Building on this assumption: what are the gaps and barriers to being more engaged?</li> <li>■ Implications of personal health records, especially proprietary ones</li> </ul>
Wisconsin	Motivational interviews Kansas City's community-wide posters	<ul style="list-style-type: none"> <li>■ Patient Activation Measurement: need case studies—what it looks like, barriers to use (from both consumer and physician)</li> <li>■ Health benefit plan design that supports alignment of consumers and physicians</li> </ul>

Representatives from Detroit, MI needed to leave the meeting before the report-out, therefore their conclusions are not included.