

October 15, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
c/o Agency for Healthcare Research and Quality
540 Gaither Road, Room 3216
Rockville, Maryland 20850
ATTENTION: Nancy Wilson

RE: National Health Care Quality Strategy and Plan

Dear Secretary Sebelius:

On behalf of the Consumer-Purchaser Disclosure Project, a collaboration of leading national and local employer, consumer and labor organizations, the 27 undersigned organizations applaud and support the Department of Health and Human Services' (HHS) effort to develop a comprehensive National Health Care Quality Strategy and Plan for aligning the myriad health care quality improvement efforts and innovative approaches taking shape in both the public and private sectors. The Disclosure Project is an initiative aimed at improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as a part of payment reform.

The U.S. health care system is at a crucial tipping point and we cannot afford to be timid in our approach to taking it back from the brink. The Affordable Care Act provides mandates for policies and programs that are aimed at improving quality and bending the cost curve, but if we do not leverage these mandates, an enormous opportunity will be wasted. We need a national strategy that inspires all stakeholders by clearly expressing goals and subsequent strategies. The final National Health Care Quality Strategy and Plan will have the power to inspire and promote change if it:

- Paints a compelling picture of the current state of the system and the frustration of those who use and pay for care;
- Clearly articulates the triple aim, making it clear that these are not three distinct aims, but are inextricably linked;
- Identifies and describes a parsimonious set of health goals that will fulfill the mission of the triple aim; and
- Identifies and makes a commitment to pursuing specific strategies that will lead to achievement of these goals.

The triple aim consists of three objectives: the need to reduce costs, improve experiences/affordability, and improve population health. We believe that the triple aim speaks clearly to the overall mission of HHS of transforming the health care system from its current fragmented state in which variability and poor quality are all too common, to one in which efforts at quality improvement and payment are aligned across the public and private sectors, where patient-centered care is the expectation, and where care meets the six aims of the Institute of Medicine as described in the groundbreaking report "Crossing the Quality Chasm," of being safe, timely, equitable, efficient, effective and patient-centered. But to make the triple aim come alive, this document needs to include succinct, actionable goals and strategies that involve alignment between the public and private sectors. Clarity is the key: without a well-oriented and detailed roadmap that includes both clear health improvement goals and critical strategies for achieving them, the National Health Care Quality Strategy and Plan may lose its ability to be a powerful tool for accelerating and guiding

change. To this end, we appreciate the opportunity to provide our responses to the following ten questions as posed by the Department.

Question 1: Are the proposed Principles for the National Strategy appropriate? What is missing or how could the principles be better guides for the Framework, Priorities and Goals?

In general, the principles stated throughout the paper are appropriate, albeit incomplete (see next paragraph). However, in order to make the final product speak more clearly to all constituents, we suggest that instead of stating the principles up front, the plan begins by discussing the pillars of the triple aim and then subsequently describes each of the stated principles in terms of how they relate to the triple aim pillars. By cross-walking the principles with the triple aim elements, the document will build a more logical bridge between the triple aim and the goals/strategies that will be necessary to meeting the triple aim. In other words, the ingredients for a strong National Health Care Quality Strategy and Plan with appropriate principles are already there, but we think the recipe could be revised somewhat. At the same time, it is crucial that the document emphasize the fact that these are not three distinct aims, but rather a *triple aim*, one that requires strategies that will simultaneously address the need to reduce costs, improve experiences/affordability, and improve population health.

As referenced above, we feel a principle should be added to greatly emphasize the need to reduce the upward cost spiral. The goals that flow from these principles should all have an element of cost containment to them, with tools and strategies that are designed in a way that does not lead to simple cost shifting, but actually decreases the amount of money spent in the system overall. We fully support adding a guiding principle that calls attention to that specific concern, with a focus on making care more efficient and addressing resource use issues in order to ensure that cost containment does not compromise quality. We suggest the following language: "*All goals and subsequent strategies will be developed within the context that our current health care system is on an unsustainable path, and address the need to make costs more rational while at the same time improving quality, access and outcomes.*"

Finally, we support principles related to 1) making information on health care services and outcomes transparent for consumers and purchasers; 2) building more accountability – from all stakeholders – into the system; and 3) prioritizing rapid cycle learning, with a particular focus on taking advantage of the states and regions which serve as learning labs for the federal government.

Question 2: Is the proposed Framework for the National Strategy sound and easily understood? Does the Framework set the right initial direction for the National Health Care Quality Strategy and Plan? How can it be improved?

Question 3: Using the legislative criteria for establishing national priorities, what national priorities do you think should be addressed in the initial National Health Care Quality Strategy and Plan in each of the following areas?

We interpret questions 2 and 3 to be interrelated, and provide the following feedback as a joint answer to both.

As noted above, we support the pillars of triple aim, and believe it is well-designed to be the framework for the National Health Care Quality Strategy and Plan, as long as it is truly framed as a set of three inextricably linked aims. As a cohesive three-point mission, it is easily understood and speaks to consumers and purchasers in terms that address their major concerns, while at the same time speaking to the need for transformational change. Below, we offer our thoughts on what the top priorities should be within each of the triple aim pillars, as well as feedback on some cross-cutting issues that are strongly related to the triple aim.

Better Care: Better care is care that is safe, timely, efficient, effective, equitable, and patient-centered, as outlined by the Institutes of Medicine in its groundbreaking report "*Crossing the Quality Chasm*." Achieving these elements requires a health care system that collects and uses information on patients' experiences of care, provides strong and consistent care coordination, eliminates disparities in care, measures and publicly reports providers' performance for accountability/public reporting and quality improvement, and pays providers accordingly based on the level of quality they provide. The priorities associated with this pillar should reflect that.

Affordable Care: The "affordable care" pillar should be strengthened by expanding on the elements of the system that must change if care is to be truly affordable. The underlying – but clearly stated – message in this pillar should be that patient-centered care is the foundation of a system that produces better outcomes and is more valued by patients, while at the same time has the potential for being more efficient and less costly. Evidence shows that when patients are made true partners in their care, and are provided with shared decision-making tools and information to make preference-sensitive decisions in conjunction with their doctors and families, they choose lower cost options/less wasteful options that often lead to improved outcomes, particularly for high volume conditions, such as those related to orthopedics and cardiology. For example, evidence now shows that physical therapy results in better health outcomes – at a significantly lower cost – than surgery for some knee conditions. It is also more effective for some spinal conditions and should be used in place of often unnecessary, expensive, and too often-performed imaging procedures. These are just two examples. Others include the high cesarean section rate, which drive the high cost of hospital deliveries and may have potential negative health implications for both mothers and infants

Integral to the effort to lower costs are structural changes in health care delivery and payment, some of which are included in the Affordable Care Act (e.g., reducing hospital acquired infections, accountable care organizations, etc). We urge you to add these to the strategy and for some to be implemented prior to ACA deadlines. As a corollary, we also urge the national strategy to include partnership with the private sector on these activities. HHS should not only implement the delivery system and payment reforms in Medicare, it should lead an effort to work with private purchasers, consumers and plans.

Also integral to the effort is the need to transform the public into active consumers of care. This can be achieved but requires that consumers receive the support (in the form of shared decision-making tools, meaningful data, education, and incentives) to be most effective in their role. We believe that this type of support is inherent in the definition of a patient-centered system, but would suggest it be highlighted. To drive this point even further, we would suggest adding language to the "affordable care" pillar on the effects of overuse, serious preventable medical errors and infections and general poor quality care on the cost landscape, and how important it is for consumers to use the information available now (and to a greater extent, hopefully, in the future) on these issues, to make decisions that reward providers who offer high quality, safe care.

Finally, in order to bend the cost curve, the "affordable care" message needs to resonate with purchasers. Thus, we suggest that priorities and strategies be developed to support employers who are trying to do the right thing by providing coverage to their employees and their dependents. In particular, some attention should be given to employers who are working to reduce the amount of spending in the system as a way to bend the cost curve, rather than simply shifting costs to their employees. Again, the point can be made here that patient-centered, high quality care costs less than our current system that is besieged by variability, overuse, and errors. We support adding language that reflects tactics that employers are using today to drive quality and value, such as providing incentives to employees to choose higher-quality providers and hospitals, making preventive services more affordable, and making it easier for their employees to improve their health status through exercise, diet, and education programs. If costs are not made more rational in a way that makes it feasible for employers to offer coverage while at the same time not shifting costs to

employees, the system will not be sustainable. Underlying this message is the fact that better care and affordable care are inextricably linked.

Health People/Healthy Communities: The National Health Care Quality Strategy and Plan should include language on the need to reduce disparities, improve preventive care, improve care for mental health and substance abuse, and establish linkages between the health care system and broader community supports.

Cross-cutting Issues: Many issues cut across the triple aim pillars. Goals for achieving affordable care, such as eliminating overuse, and improving patient safety, will rely on the strategies for providing better care, such as more comprehensive primary care, meaningful implementation of health information technology (HIT), care coordination and seamless transitions, medication management and reconciliation, and cultural change at the provider level (i.e., providers making a commitment to broad-based, continuous quality improvement). These all, in turn, have tremendous effects on the health of the population. Understanding the cross-cutting issues is critical, because we will not achieve higher quality care at lower cost if we only address issues within the silos of “better care,” “affordable care,” or “population health.” Thus, we suggest that in introducing the triple aim, a statement be made about the need for all goals, and subsequent strategies, to cut across all three pillars.

Question 4: What aspirational goals should be set for the next 5 years, and to what extent should achievable goals be identified for a shorter timeframe?

We believe the aspirational (and related, achievable, 2-3 year) goals should be in the priority areas identified by the National Priorities Partnership: Patient and Family Engagement, Care Coordination, Patient Safety, Population Health, Overuse, and Palliative and End-of-life Care, as illustrated in Table 1.

Table 1: Long and Short-term Goals, Strategies and Tactics by Priority Area

Priority Area	Aspirational 5-Year Goals	Achievable 2-3 Year Goals	Strategies/Tactics
<i>Patient and Family Engagement</i>	<ul style="list-style-type: none"> All patients will be asked for feedback on their experience of care, and this information will be used by healthcare organizations and staff to improve care. All providers will work collaboratively with patients, using shared decision-making tools, to make informed choices about preference-sensitive treatments. 	<ul style="list-style-type: none"> Implement patient experience survey in the following settings: hospital outpatient, ambulatory surgical center, ambulatory care, nursing home, and home health. Develop a two-phase approach to implementing broad shared decision-making practice, focusing on a select set of preference-sensitive conditions in phase 1, and expanding on that set in phase 2. 	<ul style="list-style-type: none"> Include patient experience survey data in all pay-for-reporting and value-based purchasing programs implemented through ACA. Require patient experience surveys as part of providers' maintenance of certification process. Mandate patient experience surveys as part of all measurement efforts associated with new models of care/payment (e.g. ACOs, medical home, etc). Implement shared decision-making measures in value-based purchasing and other incentive programs.
<i>Care Coordination</i>	<ul style="list-style-type: none"> Providers will accurately reconcile medications across all settings and phases of care for at least 50% of their 	<ul style="list-style-type: none"> Same as above, step-wise implementation of patient experience survey that is specific to care coordination, such as the 	<ul style="list-style-type: none"> Expand the medication reconciliation requirements in Meaningful Use to provide incentives to providers to achieve the first goal of accurately

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	<p>patients.</p> <ul style="list-style-type: none"> ▪ All patients' experiences with their care coordination will be collected using a validated survey tool, such as CAHPS or the Care Transition Measure survey. ▪ 30-day readmission rates will be reduced by 50%. ▪ Preventable emergency department visits will be reduced by 50%. 	<p>Care Transition Measure or CAHPS.</p> <ul style="list-style-type: none"> ▪ 30-day readmission rates for CHF, AMI and pneumonia will be reduced to an established achievable benchmark. ▪ ED visits due to adverse drug events by the elderly will be reduced to a best-in-class benchmark. 	<p>reconciling medications across all settings and phases of care.</p> <ul style="list-style-type: none"> ▪ Expand patient experience surveys to include additional questions on care coordination and transitions. ▪ Make readmission measures a centerpiece of hospital value-based purchasing, and implement the ACA policy of payment reductions for poor performance in readmissions. ▪ Require robust metrics on care coordination for accountability in new payment models (e.g. ACOs, patient-centered medical home, etc.)
<i>Patient Safety</i>	<ul style="list-style-type: none"> ▪ Preventable healthcare-associated infections, preventable serious/adverse reportable events and 30-day mortality rates for select conditions will be reduced by 75%. ▪ Reduce adverse drug events by 50 percent. 	<ul style="list-style-type: none"> ▪ Dependable, reportable measures of SSI, catheter-associated bloodstream infection, catheter-associated urinary tract infections, ventilator-associated pneumonia, c-diff and MRSA will be developed and implemented. ▪ Hospitals will collect and report data on standardized mortality rates. ▪ Adverse drug events are reduced by 20 percent. ▪ Dependable, useful measure of medication safety, based on patient identification of side effects and ADEs. 	<ul style="list-style-type: none"> ▪ Report national data on healthcare-associated infections, as required by the HHS "Action Plan to Prevent Healthcare-Associated Infections," and include these rates as mandatory for reporting in hospital value-based purchasing. ▪ Require all hospitals to use the Pronovost safe surgery checklist to reduce infection rates. ▪ Require hospitals to collect and report data on serious reportable/adverse events, and have plans in place for rapid cycle learning in the event of a serious reportable event occurrence.
<i>Population Health</i>	<ul style="list-style-type: none"> ▪ 90% of the population will be appropriately immunized, and up-to-date on other preventive clinical services that have a strong evidence-base. ▪ 75% of the population will receive evidence-based services and interventions designed to improve healthy lifestyles, and 25% of the population will make 	<ul style="list-style-type: none"> ▪ Phased-in targets for immunizations, preventive clinical services, and interventions to improve healthy lifestyle behaviors are established for interim years (e.g. 25% within 2 years, 75% rate within 5 years). ▪ Improvements in functional status for all patients, particularly those with costly conditions such as diabetes and heart 	<ul style="list-style-type: none"> ▪ Provide consumers and purchasers with financial incentives to seek and encourage, respectively, the use of preventive care. ▪ Make healthy lifestyle a critical element of new payment models, and require providers who participate in these models to not only apply these practices to their public sector patients, but to patients regardless of their payment source. ▪ Provide resources and cultural

Priority Area	Aspirational 5-Year Goals	Achievable 2-3 Year Goals	Strategies/Tactics
	significant progress in reversing unhealthy lifestyles that lead to costly conditions such as diabetes and heart disease.	disease.	change support to enable providers to play a more effective role in supporting healthy lifestyles.
<i>Overuse</i>	Reduce inappropriate care in the top ten highest-cost, highest-volume areas by 50%.	<ul style="list-style-type: none"> ▪ Phased-in approach developed whereby 3 areas are addressed every two years, with interim benchmarks selected for achievement. 	<ul style="list-style-type: none"> ▪ Make overuse measures a central feature of new payment models as well as physician and hospital value-based purchasing. ▪ Create an education campaign for consumers, leveraging purchasers, on the effects of overuse and the linkage to spiraling costs in the system. ▪ Specialty societies develop appropriate use criteria for every area identified by NPP. ▪ Specialty societies develop reporting/tracking/incentive systems to encourage conformity to professional standards. ▪ Providers implement meaningful HIT to eliminate wasteful duplication of testing and procedures. ▪ Develop incentives for providers to work together with patients to use shared-decision making tools and supports to make informed decisions that reduce overuse. ▪ Fill the gaps in overuse metrics, and implement these measures for public reporting and payment policy.
<i>Palliative and End-of-Life Care</i>	All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms (i.e., pain, delirium, and depression, etc.), and access to help with psychological, social and spiritual needs.	<ul style="list-style-type: none"> ▪ Increase consumer awareness of palliative and end-of-life care, including hospice care. 	<ul style="list-style-type: none"> ▪ Educate health care providers on the value of palliative and end-of-life care and the advantages of such care throughout many stages of illness ▪ Provide consumers and their caregivers with information and tools for shared decision-making

In addition to the priority-specific goals and strategies outlined above, the following are cross-cutting tactics that must be employed if we are to meet the goals identified in Table 1:

- **Measure Development:**
 - Measure developers work with consumers, purchasers, and payers to fill the gaps in measures that matter, including in the areas of patient safety, patient and family experience, functional status, efficiency and resource use, and care coordination.
 - Valid measures that are meaningful to consumers and purchasers are endorsed by nationally-recognized bodies for widespread use in public reporting and payment reform.
 - Priority setting by public and private sector governance bodies is truly shaped and informed by the consumer and purchaser perspectives.
- **Performance Measure Implementation and Public Reporting:**
 - Meaningful measures of outcomes, patient experience, functional status, efficiency, care coordination, and health-related quality of life are implemented by local, state, and regional entities that publicly report data for use by consumers and purchasers.
 - There is widespread availability of publicly reported data on a core set of measures that have a positive effect on patient care and consumer decision-making, including patient experience.
 - Provider performance data are stratified by race, ethnicity, preferred language, and gender to support the identification of disparities and foster quality improvement.
- **Physician Payment:**
 - Public and private sector payments are better aligned and a significant (and growing) portion of provider payments have built-in mechanisms to promote value, including care coordination.
- **Implementation of New Models of Care:**
 - New delivery system models, including Accountable Care Organizations (ACOs), patient-centered medical home (PCMH), and bundled payments, report standardized, meaningful quality performance measures to improve coordination of care and quality while reducing the rate of cost growth.
- **Affordable Accessible Care for All:**
 - Health insurance exchanges, federal and state, are driving better value and fostering transparency of cost and quality of health plans and providers for consumers and creating a platform for a transformed health care system.
 - Cost data (both per-episode and total cost) are publicly reported.

Question 5: Are there existing, well-established, and widely used measures that can be used or adapted to assess progress towards these goals? What measures would best guide public and private sector action, as well as support assessing the nation's progress to meeting the goals in the National Quality Strategy?

- **Outcome measures:** Measures should include those related to readmissions, healthcare-acquired conditions and infections, functional status, mortality, potentially-avoidable complications. Examples include (but are not limited to):
 - Rates of serious reportable events and healthcare-acquired conditions
 - 30-day mortality for AMI, heart failure, pneumonia and percutaneous intervention (PCI)
 - 30-day hospital readmission for AI, heart failure and pneumonia
 - Potentially avoidable complications for chronic conditions
 - Health-related quality of life in COPD patients
 - In-hospital (ICU) mortality

- **Care coordination and transition measures:** These measures are extremely important, but there is a significant gap right now in truly useful measures in this area. Some care transition measures that could be used/adapted include transition reports that capture movement from a hospital to a different care environment or to home but only if these measures are adapted to ensure that they truly result in appropriate transitions that include patient engagement. “Check the box” measures of checklists are not going to be beneficial. In addition, care coordination and transition measures should be HIT-enabled, given the linkage between meaningful use of HIT and successful care coordination. Current measures that could be implemented include:
 - Timely transmission of transition record to primary care, specialist, and other health care setting (see note above about ensuring this not become a “check the box” measure)
 - Transition record with specified elements received by discharged patients
 - CAHPS patient experience survey
 - Care Transition Measure (CTM-3)
 - Medication adherence
- **Efficiency:** Imaging measures have been in development, but efficiency must go much farther to address costs and other areas of overuse. Examples of what is available now include:
 - Low back pain use of imaging studies
 - Imaging overuse of CT, MRI and Cardiac Imaging
 - Emergency Department throughput measures
 - Rate of cesarean section for low-risk first birth women
- **Functional Status:** Functional status tools that identify pre- and post-treatment physical function, mental health status (e.g. depression severity), social/role function (e.g. ADL), and other measures of functional health such as pain, vitality, perceived well-being, and health risk status.
 - Medicare Health Outcomes Survey (HOS)
- **Patient Experience:** Current patient experience surveys are adequate, but must be strengthened to include additional questions on care coordination and transitions and shared decision-making.
 - CAHPS
 - Family Evaluation of Hospice Care (FEHC)
 - Medical Home System Survey
- **Patient Safety:** This overlaps with outcomes, to include all never events/serious reportable events.
 - Rates of infections including surgical site, central-line associated blood stream (CLASB), Catheter-associated Urinary Tract (CAUT), and ventilator associated-pneumonia (VAP), MRSA, and Clostridium difficile
 - Rates of adverse drug events (ADE)

Question 6: The success of the National Health Care Quality Strategy and Plan is, in large part, dependent on the ability of diverse stakeholders across both the public and private sectors to work together. Do you have recommendations on how key entities, sectors, or stakeholders can best be engaged to drive progress based on the National Health Care Quality Strategy and Plan?

To achieve the goals set out by the National Health Care Quality Strategy and Plan, HHS should solicit the opinions and concerns of consumers and purchasers by giving them strong representation on all key committees – again, in both the public and private sectors – that are doing work related to it. This is a necessary step to ensure that “quality” is being determined by those who use and pay for care, and not solely by those who supply it. Consumers and purchasers are in a unique position to speak to many of the challenges and opportunities that exist in making the health care system more patient-centered. We are excited about the potential for the National Strategy to spur the

conversation with consumers and purchasers about what are their true goals, desires and concerns, and then urge that the federal government make resources available to address them.

Other efforts to bring stakeholders across the public and private sectors together to engage in the goals and strategies outlined in the National Health Care Quality Strategy and Plan should include conducting market research, focus groups, message testing, and outreach events with consumers and purchasers. A model for this type of outreach is the work that was done to roll out Medicare Part D, which launched successfully and provided CMS with a great deal of information on how to work through community-level resources such as religious institutions, radio stations, etc. We recommend re-deploying that expertise for marketing and getting buy-in to the National Health Care Quality Strategy and Plan. We also recommend HHS continue its collaborative work with already-established public-private collaboratives such as the National Priorities Partnership, and leverage work being done through that effort to bring together multiple stakeholders from both the private and public sectors.

Finally, HHS should continue its good work of convening listening sessions and open door forums on existing and new policies, both in Washington D.C. as well as in the states and communities. Lessons learned from these forums should be made transparent via annual updates on national and individual states' progress in implementing the National Health Care Quality Strategy and Plan. Efforts should be made through all of this to include innovative work being done at the state and regional level, and highlight the states and regions as "learning laboratories" for federal government.

Question 7: Given the role that States can play in organizing health care delivery for vulnerable populations, do the Principles and Framework address the needs and issues of these populations?

The framework and principles do address the general needs and issues of all vulnerable populations. However, the language could be strengthened if we want them to truly speak to the challenges faced by vulnerable populations, and the state and local systems that are trying to meet their needs. We suggest simply that the principle which now reads "The strategy and goals will address all ages, populations, service locations, and sources of coverage," be amended to read "The strategy and goals will address all ages, populations, service locations, treatment interventions and sources of coverage, and will recognize the challenges faced by those with multiple chronic health conditions." We note that "vulnerable populations" should refer to socio-economic status, as well as to those with multiple chronic conditions. If strategies are undertaken to meet the goals identified above in Table 1, then the system as a whole will be transformed in a way that all populations, vulnerable or not, will reap the benefits of a patient-centered delivery system. In other words, by ensuring that vulnerable populations – including individuals with multiple chronic conditions and their family caregivers – get the comprehensive, coordinated, and patient and family-centered health care they want and deserve, it will result in a system that works for all populations. The underlying truth is if we can make the health care delivery system work for these individuals, we can make it work for everyone. In the meantime, it is important to recognize that segments of the health care system that serve vulnerable populations will need additional supports and assistance to reach these goals, particularly where there has been a long history of health care disparities.

Question 8: Are there priorities and goals that should be considered to specifically address State needs?

The National Strategy should address the need that states have for all-payer databases that include Medicare cost data. This will give them critical information that will allow them to leverage their resources, address the needs of their populations, and develop their own strategies for quality improvement.

Another specific goal should be around the need to ensure that the Health Insurance Exchanges are a success by requiring that health plans participating in exchanges at the federal and state levels must concurrently report on the same quality elements for their non-exchange market products. This will provide states with leverage to improve health plan quality, and raise all boats.

Finally, the National Strategy must address the issue of state variability, and the ethical need for our health care system to ensure that a consumer living in Mississippi receives the same high quality care as someone in Minnesota. Regional variation should not determine one's health care fate. Thus, goals that specifically address states' needs should focus on transparency and disparities across and within states, drive the development of policies that provide assistance to poor performers, and use federal resources to drive improvement and equity.

Question 9: What measures or measure sets should be considered to reflect States' activities, priorities, and concerns?

Measures used to achieve the goals laid out in the strategy should be consistent across states in order to allow for national comparisons. However, at the same time, HHS should look to the states and regions to see which measures and measure sets are in use today, what the effects have been on their health care systems, and take into consideration the need for states to be able to continue on the path that many are already on in terms of measuring and reporting on their systems. Many states have been extremely innovative in the area of measurement and public reporting, and it will be important to balance the need for consistent measurement across the country with the good work that many states are already doing.

Question 10: What are some key recommendations on how to engage with States and ensure continued alignment with the National Quality Strategy?

We recommend HHS consider the following:

- Work with the states to designate – in each state -- a Chief Quality Officer. This person would be a liaison to the federal government and coordinate state and federal efforts, as well as work with other states on their innovative strategies;
- Provide technical assistance to states on the National Strategy and its implementation;
- Assist states in identifying, developing and potentially coordinating efforts to assess patient experience in Medicaid and other state-run benefit programs such as the state employee benefit program; and
- Develop annual state-specific reports assessing progress on the National Strategy, or expand on the current annual Agency for Healthcare Research and Quality (AHRQ) report.

On behalf of the undersigned consumer and purchaser organizations, we thank you for your efforts and your responsiveness to our comments. If you have any questions, please do not hesitate to contact either of the Disclosure Project's co-chairs, David Lansky, President and CEO of the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

AARP
AFL-CIO
American Benefits Council
American Federation of State, County & Municipal Employees
American Hospice Foundation
Center for Payment Reform

Childbirth Connection
Consumers' CHECKBOOK/Center for the Study of Services
Consumers Union
Employer's Coalition on Health
Employers Health Coalition of Ohio, Inc.
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
Louisiana Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
National Retail Federation
New York Business Group on Health
Pacific Business Group on Health
Puget Sound Health Alliance
South Carolina Business Coalition on Health
The Alliance
The Leapfrog Group