Federal Government Initiatives to Improve Healthcare Quality

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Quality Colloquium
August 22, 2005
AHRQ’s Mission

Improve the quality, safety, efficiency and effectiveness of health care for all Americans
NIH

Biomedical research to prevent, diagnose and treat diseases
HHS Organizational Focus

NIH
Biomedical research to prevent, diagnose and treat diseases

CDC
Population health and the role of community-based interventions to improve health
HHS Organizational Focus

NIH
Biomedical research to prevent, diagnose and treat diseases

CDC
Population health and the role of community-based interventions to improve health

AHRQ
Long-term and system-wide improvement of health care quality and effectiveness
Initiatives

- National Healthcare Quality and Disparities Reports
- Quality, safety and health information technology
- New patient safety legislation
- Effective Health Care Program
- Educating consumers about healthcare choices
National Healthcare Quality and Disparities Reports

- Congressionally mandated annual reports focus on quality of and disparities in U.S. health care
  - *Quality Report* finds that quality is improving and identifies areas which are in need of major improvements
  - *Disparities Report* indicates that there are pervasive disparities related to race, ethnicity, and socioeconomic status
First national comprehensive efforts to measure the quality of health care in America and differences in access to health care services for priority populations

- Presents data for clinical conditions, including cancer, diabetes, end-stage renal disease, heart disease, HIV and AIDS, mental health, and respiratory disease
- Includes data on maternal and child health, nursing home and home health care, and patient safety

Reports available at: http://www.qualitytools.ahrq.gov
How Reports Are Related

- NHQR is foundation
  -- analyzes quality across components of quality and priority conditions
- NHDR examines quality and access for priority populations
Disparities in Quality of Care for Medicare Enrollees

Schneider et al. JAMA 2002
Take Home Points

- Poorer quality care consistently observed for racial and ethnic minorities, worse if combined with low income and education.
- Patterns vary by condition, service and by community.
- *Improvement is possible*
3 new studies, including an AHRQ-supported study, suggest some improvements in health care equality among black and white U.S. residents. Significant disparities remain for black patients, including less access to operations tests, medications and other treatments.
Public/private partnership to reduce disparities in health care for people with diabetes and other conditions (AHRQ and RWJ)

Over next 3 years, collaborative will test ways to improve collection and analysis of data on race and ethnicity and match data to existing quality measures to close gap in care

9 National Health Plans Sponsored by nine of Nation’s largest health insurance plans, and other organizations (serving commercial, Medicare, and Medicaid).
Participating Health Plans

- AETNA
- *Anthem BCBS
- Cigna HealthCare
- Harvard Pilgrim
- Health Partners
- Highmark Blue Cross Blue Shield
- Kaiser Permanente
- Molina Healthcare
- United Healthcare (UnitedHealth Group and Ovations, Senior and Retiree Services)
- *Wellpoint

TOTAL ENROLLEES = 76,748,227

*Anthem and Wellpoint have merged to form Wellpoint, Inc.
Quality *is* improving, slowly

- **Most measures have shown some improvement**
  - Nearly twice as many measures have improved as have deteriorated

- **Some specific examples:**
  - 37% decrease in percentage of nursing home patients who have moderate to severe pain
  - 34% decrease in the hospital admission rate for uncontrolled diabetes
  - 32% increase in the percentage of persons living in long-term care or nursing home facilities who were given pneumococcal vaccinations
Pace of Change Varies Across Care Settings

- Of 98 measures with trend data, 88 can be mapped to care settings.
- Some improvement seen in all settings.
- However, change in performance varies across settings.

- Median percent change:
  - Hospital care: 5.4% (24 measures)
  - Ambulatory care: 1.4% (49 measures)
  - Home health care: 3.0% (12 measures)
  - Nursing home care: 14.7% (5 measures)
AHRQ Quality Connect

- Help States **identify where they need to improve** health care quality
- Assist states in **developing and implementing action plans** to improve health care quality
- Provide **technical assistance** for new and existing quality improvement efforts at the State and local level
- Facilitate **more rapid adoption** of promising quality improvement practices through communication among states and local communities, peer based learning networks, and facilitation of State teams
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Bridging the Quality Chasm

Where we are

Health IT

Innovation

Diffusion

Adoption

Where we want to be
Intersection of Safety, Quality and Health Information Technology

- Support diffusion of HIT
  - 38 states
  - 40 million Americans

- Improve medication safety
  - CMS e-prescribing demos

- Provide HIT technical support to the safety net
  - Community health centers
  - Critical access hospitals
  - Public hospitals (HHC)
Health IT: A Means to An End

AHRQ’s Role: Prove Health IT works in real-life clinical settings

- How does Health IT drive safety and quality improvement?
- How can we ensure that doing the right thing is the easy thing to do?
- How can we use the power of Health IT to provide better quality measures faster?
Proportions of patients receiving the appropriate discharge prescriptions

- Intermountain Health Care QI effort on CVD

- Results:
  - 90% prescription rates
  - 27% decrease in unadjusted absolute death rates

How AHRQ Is Helping

- We fund grants and contracts to promote Health IT investment, especially in rural and underserved areas.
- We evaluate what works best, where barriers exist, and how Health IT can be successfully implemented.
- We offer technical assistance through our National Resource Center on Health Information Technology to help clinicians make the leap from pencils to PDAs.
AHRQ Health IT Portfolio

State and Regional Demonstrations
5 yr

Planning
1 yr

Implementation
3 yr

Demonstrating Value
3 yr

National Resource Center for Health IT
Health IT Grants

Promote access to Health IT

- $139 million investment over 5 years
- Over 100 grants to communities, hospitals, providers, and health care systems to help in all phases of the development and use of Health IT
- The grants spread across 40 states
- Special focus on small and rural hospitals and communities.
HIT, Quality and Safety

- Outpatient Advanced CPOE and EMR
  Avoid 2.1 million adverse drug events
- Inpatient CPOE and EMR
  Decrease serious medication errors by 55%
- Healthcare information exchange and interoperability between settings
- Improve decision-making at the point-of-care through complete information access

Source: CITL
Building HIT Evidence Base

- Electronic Health Records
- Clinical Decision Support
- Electronic Prescribing
- Use of hand-held devices
- Consumer-directed IT
**Major Finding:** While computerized physician order entry (CPOE) is expected to significantly reduce medication errors, systems must be implemented thoughtfully to avoid facilitating certain types of errors.

Study looked at clinicians’ experience in using one CPOE system at a major urban teaching hospital.

Implementation problems can be minimized through testing before products are marketed and through adaptation to meet the needs of individual clinical settings.

Health IT and Patient Safety

Key challenges

- Tap and collect ongoing resources
- Convince providers to buy in
- Understand existing workflow
- Understand HIT impact on workflow
- Data standards/integration
- Get vendors to make needed changes
Health IT Opportunities

Reengineer processes to improve patient safety

- As we migrate to a health IT infrastructure, put effective processes in place as the same time
- Augment health IT applications for error reduction, CPOE and other decision support tools
- Build in the necessary disciplines and team approaches
Health IT Opportunities

Remove barriers

- Build interoperable systems
- Standardize medical nomenclature
- Examine privacy issues
- Prepare the health care sector and clinicians to use full potential of health IT
- Learn and share best practices through the AHRQ Resource Center and other channels
Health IT Opportunities

Develop/disseminate evidence

- Assess effectiveness of different treatment options for high-priority conditions (MMA)
- Use health IT channels to deliver important information faster and more effectively, especially in patient safety
- Identify new research needed
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Major provisions of Act:

- Creates “Patient Safety Organizations (PSOs)"
- Establishes “Network of Patient Safety Databases”
- Mandates Comptroller General to study effectiveness of Act (by 2010)
- Is a completely voluntary system
Goals

- To encourage providers to identify & correct medical errors & threats to patient safety by ensuring that their work with PSOs cannot be used against them in courts or in disciplinary proceedings.

- To encourage aggregation of cases by & among PSOs, creating a network of patient safety databases.
Patient Safety Organization

- Private or public entity
- Meets PSO criteria & complies with policies/procedures
- Self-certifies initially & every 3 years thereafter
- Certification is accepted by Secretary or not; may be revoked
PSO Criteria

- Mission to improve quality & safety
- Has appropriately qualified staff
- Within 24 months of listing, has contracts with more than 1 provider
- Is not (component of) health insurer
- Collects data in standardized manner
- Uses work product to provide feedback & assistance & minimize patient risk
PSO Activities

- Conducts efforts to improve patient safety & quality
- Collects & analyzes data, reports, records, root cause analyses
- Develops/disseminates information to improve patient safety; provides feedback
- Encourages culture of patient safety
- Maintains procedures to preserve confidentiality of all work product
Network of Patient Safety Databases

- Interactive evidence-based management resource
- Capacity to accept, aggregate, & analyze non-identifiable data voluntarily reported by PSOs, providers, & others
- Data to be used to analyze national & regional statistics, including trends & patterns of health care errors
- Information to be made public & reported annually (in AHRQ’s National Healthcare Quality Report)
Likely Role of AHRQ

Bill vests all authority in Secretary but law is in AHRQ statute. Likely AHRQ duties:

- Elaborate criteria for PSO certification
- Provide technical assistance to PSOs to ensure common definitions to permit valid comparisons & analyses, develop & improve methodology, etc. (annual meeting required)
- Create Patient Safety Database to aggregate non-identifiable data shared by PSOs for analyses by AHRQ & others
- Incorporate analyses of trends/patterns/findings in AHRQ’s *National Healthcare Quality Report*
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Evidence Report: Episiotomy

**Major Finding:** Routine use of episiotomy for uncomplicated vaginal births does not provide immediate or longer term benefits for the mother

- Without episiotomy, women were more likely to give birth without perineal damage, less likely to need suturing, and more likely to resume intercourse earlier

AHRQ Evidence Report No. 112, Episiotomy Use in Obstetrical Care, May 2005
Bad Medicine

According to a newly published analysis of the effectiveness of episiotomies, the procedure has no benefits whatsoever. In fact, an episiotomy — a pre-emptory incision, theoretically intended to prevent pregnant women from experiencing torn tissue during labor — probably makes such complications more likely and causes more pain and worse side effects as well.

This result was not surprising to the scientists who wrote the report, published this week in the Journal of the American Medical Association, because the most important research on the subject had already been done. The scientists carrying out the analysis did not conduct new clinical studies but rather sifted through the results of more than 900 medical articles on the subject, picked the most informative and pooled the information. When looked at as a whole, the evidence against this unnecessary and damaging procedure, in widespread use since the 1930s, was overwhelming.

But although the results were already “obvious,” in the words of the epidemiologist leading the study, they will clearly come as a surprise to the doctors who still carry out some 1 million episiotomies in this country every year — if they ever hear about it. Indeed, that scientists’ long-standing doubts about the medical value of episiotomies weren’t already well known underlines the profound problems with the transmission of new medical information within our health care system. Just like recent large-scale studies showing that the common prescription of estrogen to post-menopausal women carried serious health risks, this one is further proof of the value of testing even the most common assumptions — and of the need for the wider use of evidence-based medicine.

It is also further proof of the value of the Agency for Healthcare Research and Quality, which commissioned the episiotomy study at the behest of the American College of Obstetricians and Gynecologists. The agency is one of the few institutions in the country that does regular, neutral investigations of best medical practices. Yet it is a tiny agency, by federal government standards, and lives under the shadow of budget-cut threats. Both money and pain could be saved if its role were quietly expanded and its findings more loudly promoted.
Major Finding: One in five patients hospitalized for heart attack suffers from major depression
- These patients may be more likely than other heart attack patients to need hospital care again within a year for a cardiac problem
- May be 3x more likely to die from a future attack or other heart problems

Certain antidepressants may reduce symptoms of depression

AHRQ Evidence Report No. 123, Post-Myocardial Infarction Depression, May 2005
Effective Health Care Program

- Designed to support the new Medicare prescription drug benefit in 2006
- Mandated by Section 1013 of the Medicare Modernization Act to improve the quality, effectiveness and efficiency of health care delivered through Medicare, Medicaid and the S-CHIP programs
- Will help patients, clinicians and payers choose the best treatments for their needs
- Builds on years of experience gained through AHRQ’s Evidence Based Practice Centers
Legs of the Program

- Evidence Synthesis
- Evidence Generation
- Evidence Communication
Top 10 Conditions Affecting Medicare Beneficiaries

- $15 million initiative, authorized by MMA Section 1013, to develop state-of-the-art information about effectiveness of interventions, including prescription drugs, for top 10 conditions affecting Medicare beneficiaries:

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Arthritis and non-traumatic joint disorders</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease/asthma</td>
</tr>
<tr>
<td>Dementia, including Alzheimer’s disease</td>
</tr>
<tr>
<td>Depression and other mood disorders</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
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<tr>
<td>Peptic ulcer/dyspepsia</td>
</tr>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Stroke, including control of hypertension</td>
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In the Hospital, a Degrading Shift from Person to Patient

By Benedict Carey

August 16, 2005 story Includes findings from AHRQ, Kaiser Family Foundation and Harvard School of Public Health survey published Fall, 2004
Awash in Information, Patients Face a Lonely, Uncertain Road

By Jan Hoffman

August 14, 2005 story
Putting the Patient in the Driver’s Seat
Five Steps to Safer Health Care

1. Ask questions if you have doubts or concerns.
   Ask questions and make sure you understand the answers. Choose a doctor you feel comfortable talking to. Take a relative or friend with you to help you ask questions and understand the answers.

2. Keep and bring a list of ALL the medicines you take.
   Give your doctor and pharmacist a list of all the medicines that you take, including over-the-counter medicines. Tell them about any drug allergies you have. Ask about side effects and what to avoid while taking the medicines. Read the labels when you get your medicines, including all warnings. Make sure your medicine is what the doctor ordered and know how to use it. Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.
   Ask when and how you will get the results of tests or procedures. Don’t assume the results are fine if you do not get them on time. Ask to see them when expected, be it in person, by phone, or by mail. Call your doctor and ask for your results. Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.
   Ask your doctor about which hospital has the best care and which is best for your condition if you have more than one hospital to choose from. Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.
   Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, “Who will manage my care when I am in the hospital?” Ask your surgeon, “Can I ask questions whenever I need to?” Ask your surgeon, “How long will I stay?” Ask the surgeon about any allergies, bad reaction to medicines, and any medications you are taking.
Outreach and education

- Town hall meetings in Chapel Hill, Oklahoma City and Philadelphia
- Expanded dissemination of consumer healthcare information through publications such as “Next Steps After Your Diagnosis”
- More information on the Internet
- HHS radio and TV
- PSA collaboration with the Ad Council
- Consulting with Hollywood writers and producers
Making strides

“I’m running as fast as I can, but my legs still need to grow!”
Your questions?