



AHRQ and HHS Efforts to Improve Quality

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Director

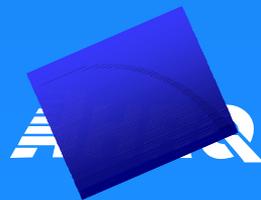
March 26, 2003





Overview

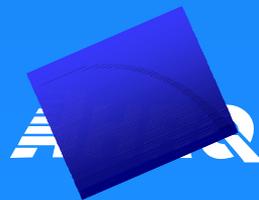
- Current Challenges and Context
- Federal Role in Promoting Quality
- Recent Developments and Issues
- Future Directions





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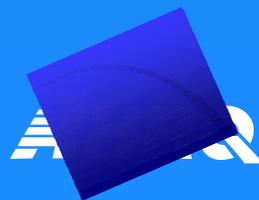
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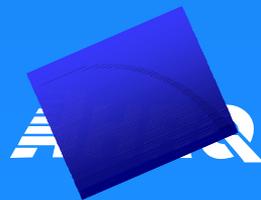
- Structure
- Process
- Outcomes





Measuring Quality

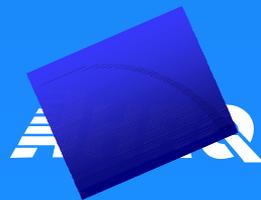
- **Structure** -- Are the right elements in place to be able to provide quality?
- **Process** -- Are the right things done to the right people at the right time?
- **Outcome** -- Is the result as good as it should have been given current knowledge?





Context

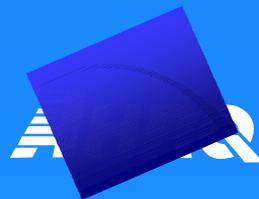
- Structural measures do not reliably predict quality
- Growing demand for evidence of performance and public reporting of same
- Outcomes considered best – but outcomes are not actionable, and require substantial adjustment for fair comparison





Data Sources

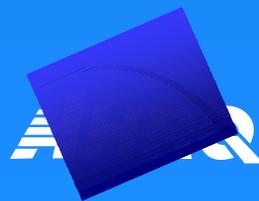
- Administrative data: e.g., hospital discharge abstracts; billing -- limited clinical detail
- Clinical information systems: more detail; variable penetration
- Surveys: only source for patients' experiences and patient reported outcomes
- Chart Reviews: expensive; subject to reporting omissions





Context -- 2

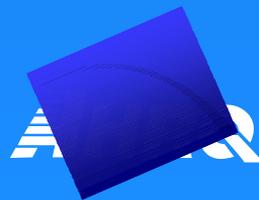
- Most efforts, in U.S. and other countries, use condition-specific approach, but
- Most efforts are setting specific – limiting what we'd like to know
- Aggregate or composite scores -- ??relevance
- Available measures, and available evidence linking process and outcome, is variable





Growing Impatience

- Precision and consensus regarding management of ('X') greatly exceeds translation into practice
- Most clear successes of translating research into practice have focused on underuse of effective treatments; less focus on misuse and overuse
- Next frontiers: linking incentives with improvement; IT; leadership





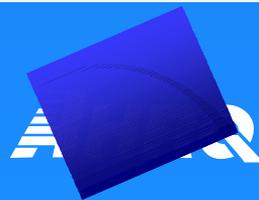
Recent Press Coverage on Quality

**U.S. Medical Care Improves Overall;
Although gains have been made since first study,
quality of treatment falls far short of optimal**

**Medicare Treatment
Improved, But Still
Varies by Region**

**Hospitals
Will Be Rated
on Their
Performance**

**Patients May
Become
Comparison
Shoppers**

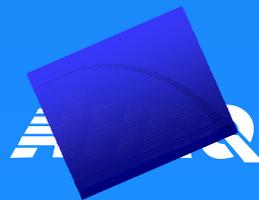




The New York Times

Errors That Kill Medical Patients

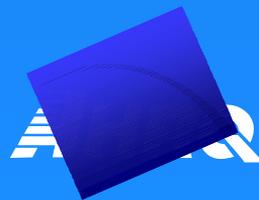
New York Times, December 18, 2002





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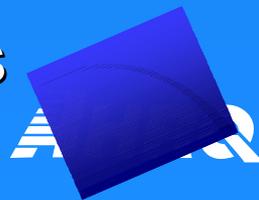
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Ten Roles of Government in Health Care Quality

- Purchase health care
- Provide health care
- Assure access for vulnerable populations
- Monitor health care quality
- Regulate health care markets
- Inform health care decision-makers
- Support acquisition of new knowledge
- Support development of health technologies and practices
- Develop the health care workforce
- Convene stakeholders





Federal Role in Quality: Examples

Role

1. Purchase
2. Provide
3. Support programs
4. Research
5. Develop

Example

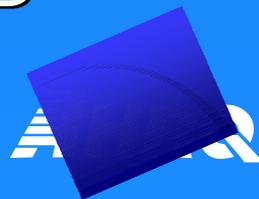
Medicare, TriCare

Veterans Administration
(VA), Dept. of
Defense(DoD),

Community Health Centers

AHRQ, VA

AHRQ, CMS, VA, DoD





Federal Role in Quality: Examples

Role

Example

6. Convene

Labor, CMS, AHRQ

7. Regulate

Labor, **FTC**

8. Inform

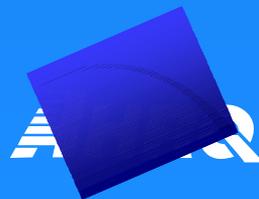
NTSB, CMS, AHRQ, Labor

9. Develop workforce

HRSA, VA, AHRQ

10. Assure access

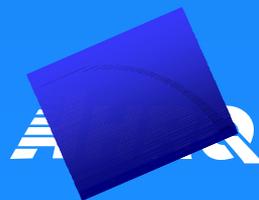
HRSA



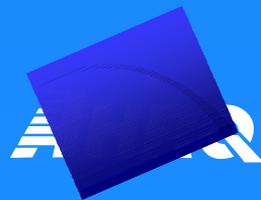
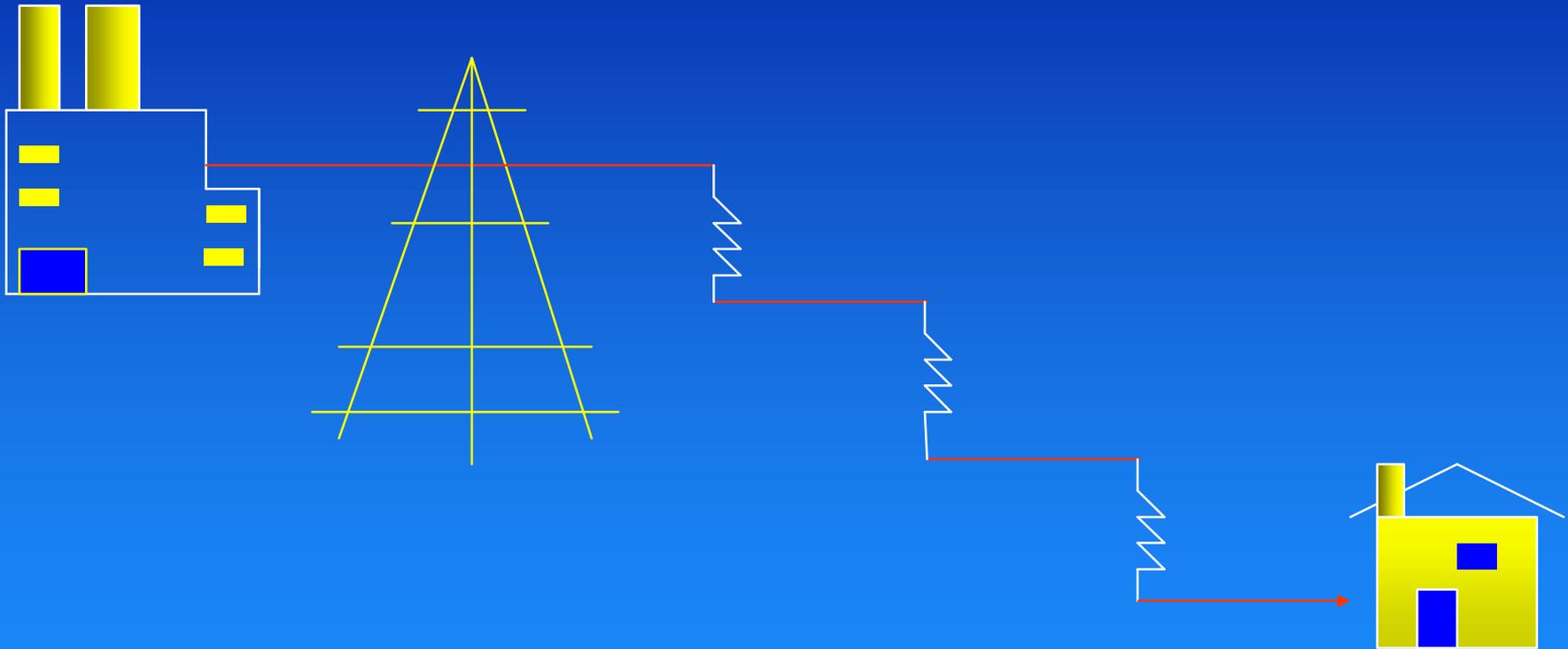


Non-Federal Roles in Quality

- Accreditation of organizations
- Certification of individuals
- Credentialing of individuals
- Licensing of individuals and organizations
- Judicial system: malpractice
- Professional societies
- Continuing education
- Purchasers



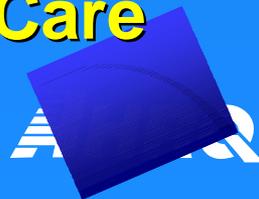
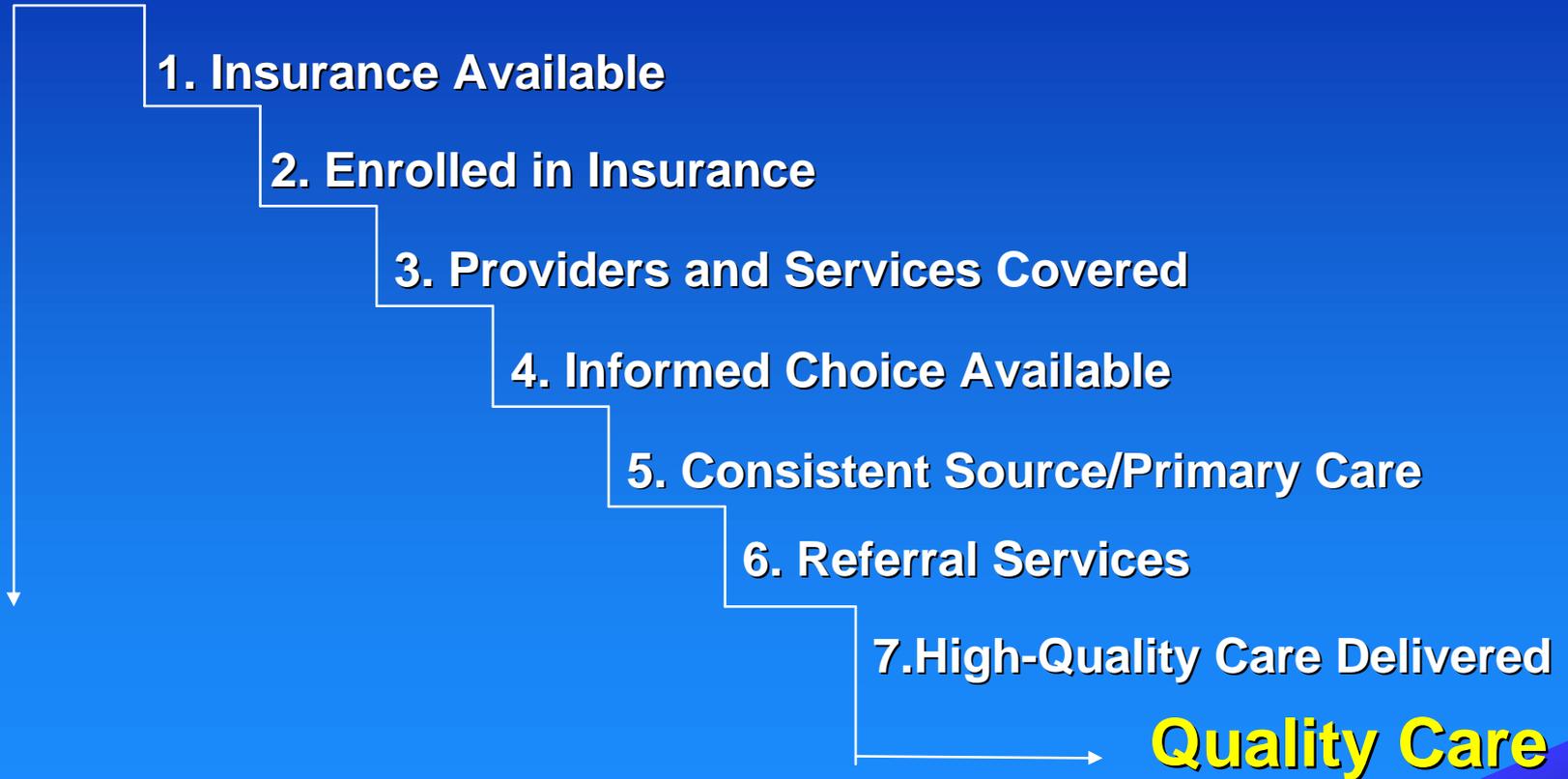
Voltage Drop





Voltage Drops to Quality

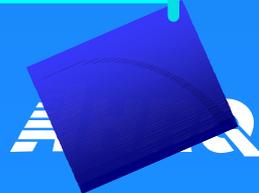
Population





AHRQ Customers and Goals

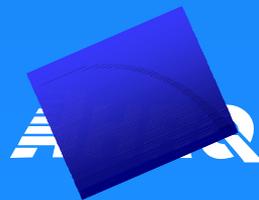
	Clinical Decisionmakers	Health System Decisionmakers	Public Policy Decisionmakers
Outcomes			
Quality			
Cost, Use and Access			





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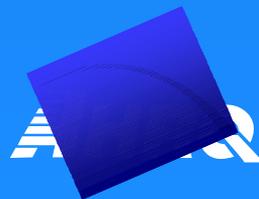
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Consumer Assessment

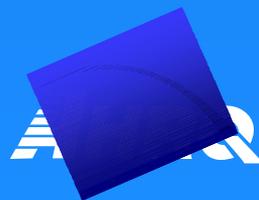
- What role does the patient have in defining what is important to assess about quality?
- What role does the patient have in assessing the quality of care?





Categories of Care Activities

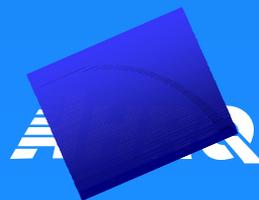
- ***Technical care*** – Application of science and technology of medicine to manage personal health problems
- ***Interpersonal care*** – Interaction between the patient/consumer and the health care system arrange and receive care





CAHPS[®] Core Instruments

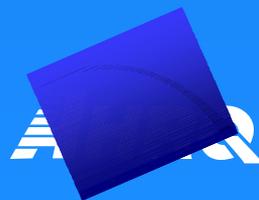
- Adult core questionnaire (46 items)
 - Commercial
 - Medicaid
 - Medicare
 - Managed care
 - FFS
 - Disenrollment
- Child core questionnaire (46 items)
 - Commercial
 - Medicaid





CAHPS® Instruments: Supplemental Topics

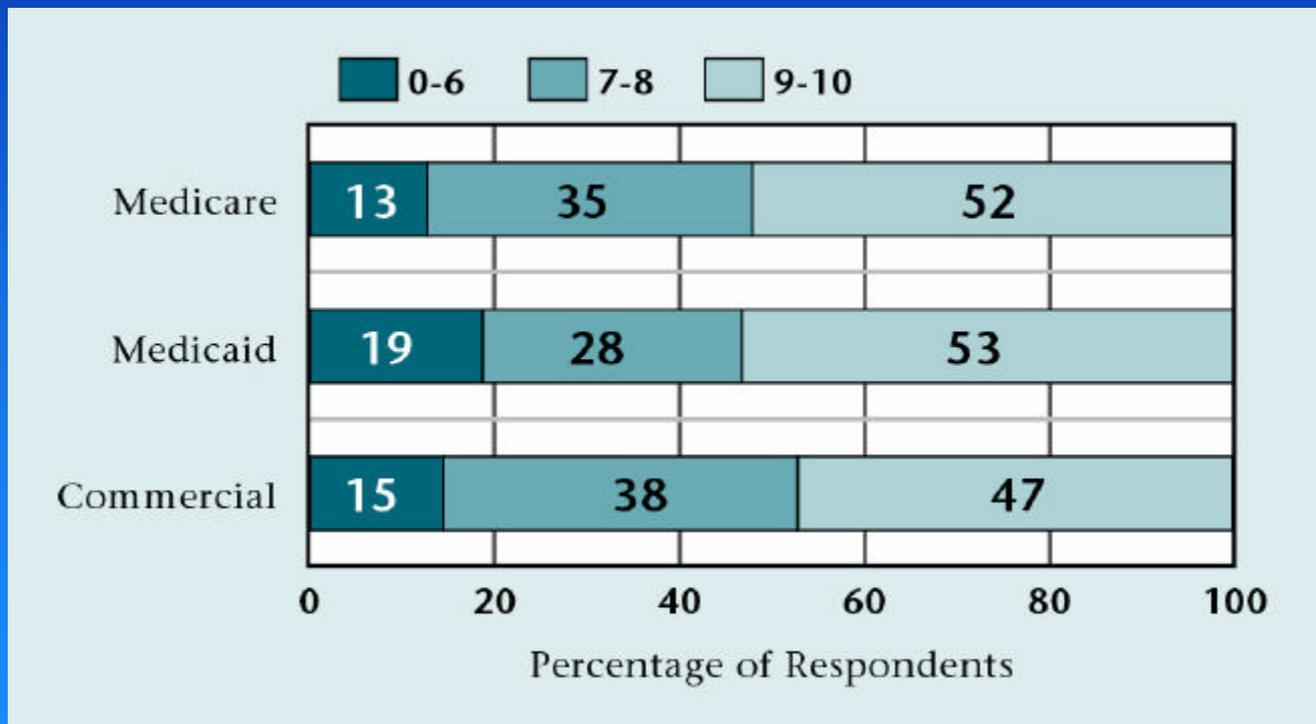
- Communication
- Interpreter
- Dental care
- Mental health
- Chronic condition (adult and child)
- Pregnancy care
- Prescription medicine
- Transportation



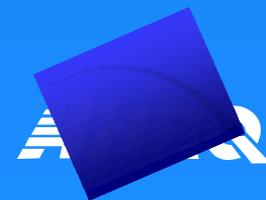


Consumers Rate Their Overall Health Care Highly

Adult Ratings of All Health Care



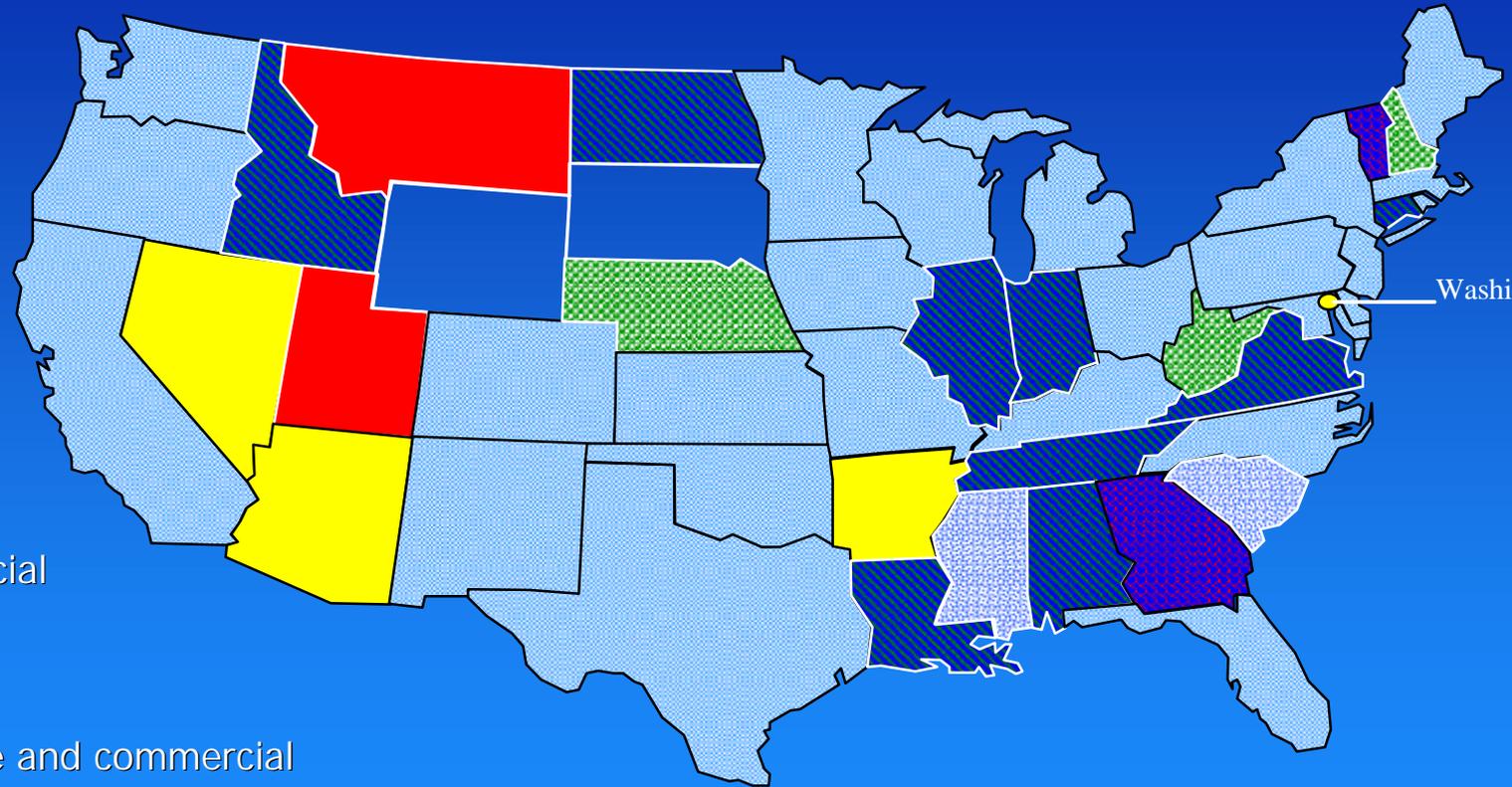
Ratings: 0 is "worst possible" and 10 is "best possible"



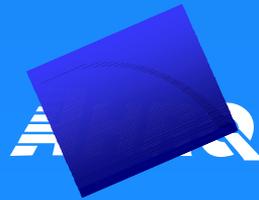


Specific Approaches: Populations Surveyed by CAHPS, as Reported to the CAHPS Survey Users Network

(through 2000)



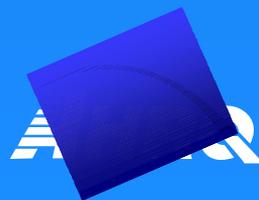
- Commercial
- Medicaid
- Medicare
- Medicare and commercial
- Medicare and Medicaid
- Medicaid and commercial
- Medicare, Medicaid, and commercial





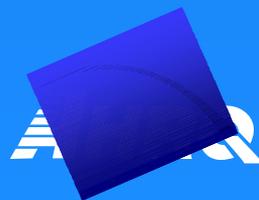
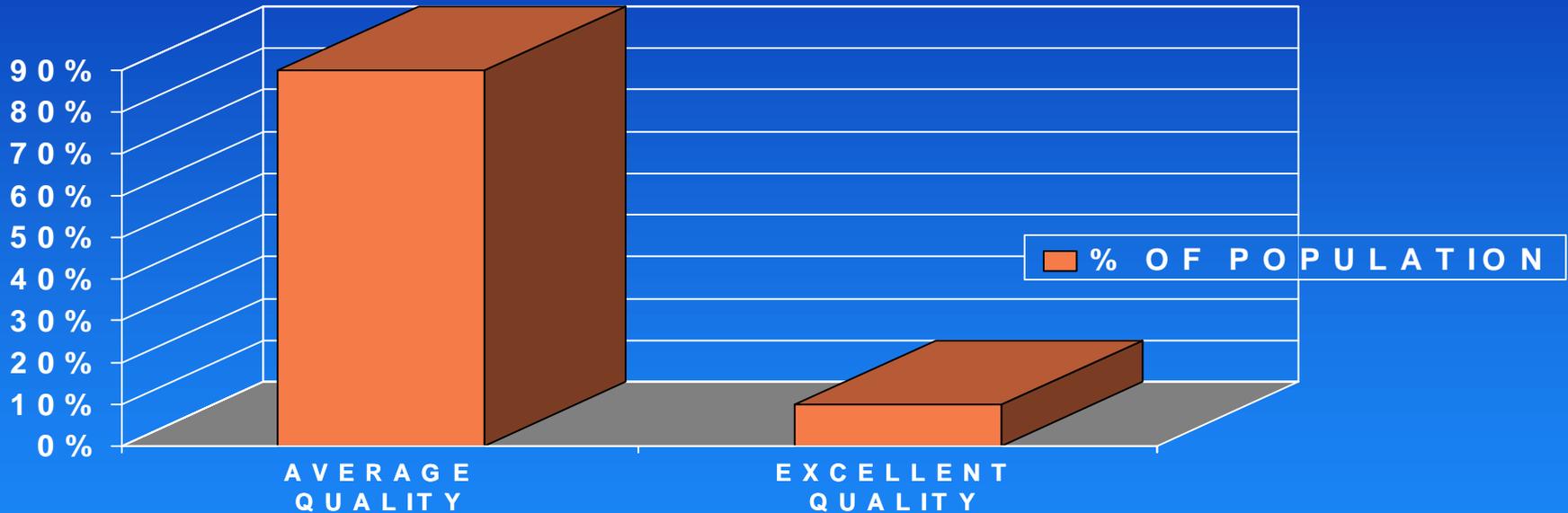
Recent Developments

- Nursing Home Initiative
- Home Health Care Initiative*
- AHA-JCAHO-VHA Hospital reporting initiative*
- Patient experience in hospitals*
- Bar coding
- IT standards (*)





The Quality Gap We Must Bridge



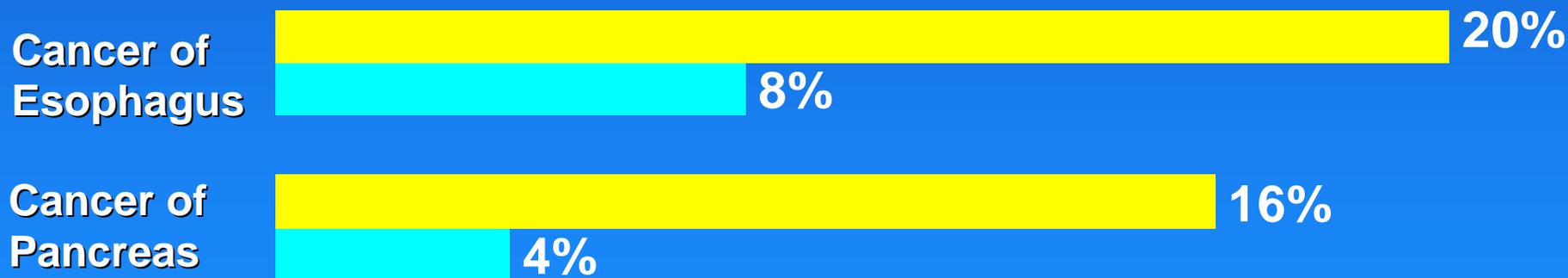


AHRQ Research Study: Hospital Volume and Surgical Mortality in the U.S.

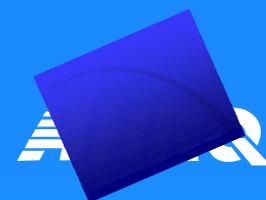
- **Major Finding:** Elderly patients who had any of 14 high-risk cardiovascular or cancer surgeries fared better in more experienced hospitals

Death Rate Differences: Low-Volume vs. High-Volume Hospitals

■ Low-Volume
■ High-Volume



J. Birkmeyer,, A. Siewers, E. Finlayson, et al., Hospital Volume and Surgical Mortality in the United States, *NEJM*, April 2002

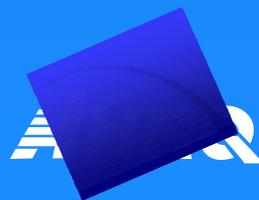




AHRQ Research Study: Identifying Successful Hospital Quality Improvements

- **Major Finding:** Hospitals that were more likely to prescribe beta-blockers shared similar characteristics:
 - Solid support from their hospital administration
 - Strong physician leadership
 - Shared goals of improving medical practice
 - Effective way of monitoring progress
- Conducted by Yale University School of Medicine

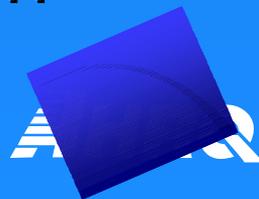
E Bradley, E Holmboe, J Mattera, et al., A Qualitative Study of Increasing B-Blocker Use After Myocardial Infarction, *Journal of the American Medical Association*, May 23, 2001





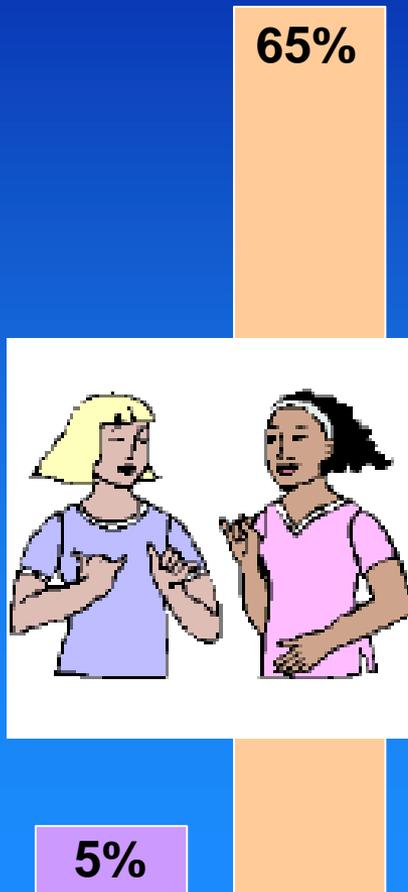
AHRQ Research Study: Nursing Staff Levels and Patient Outcomes

- **Major Finding:** Direct link between nurse staffing levels and patient complications and deaths in hospitals
- Low RN staffing associated with rates of serious complications:
 - Pneumonia
 - Shock
 - Cardiac arrest
 - Gastrointestinal bleeding
- Ongoing partnership with AHRQ, HRSA, CMS, and National Institute for Nursing Research



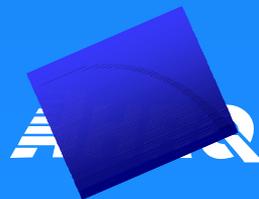


AHRQ Research Study: Team Approach to Testing for Chlamydia



- Team-oriented approach to testing for chlamydia increased screening rate of sexually active 14- to 18-year old female patients from 5% to 65% in a large California HMO study
- New screening system may help reduce estimated \$4 billion annual treatment cost

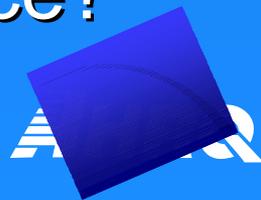
M Shafer, The effect of clinical practice improvement intervention on chlamydia screening among sexually active adolescent girls, *JAMA*, December 11, 2002





AHRQ Strategy Components

- **Building the knowledge base:**
 - The effectiveness question: What works?
 - Clinical
 - Organizational
 - The TRIP question: How do we get people/systems/policymakers to do or use what works?
- How do we support the widespread implementation of what works?
- How do we sustain evidence based practice?

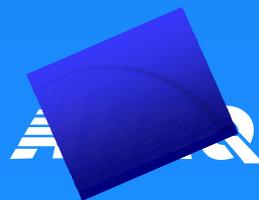




National Guideline Clearinghouse

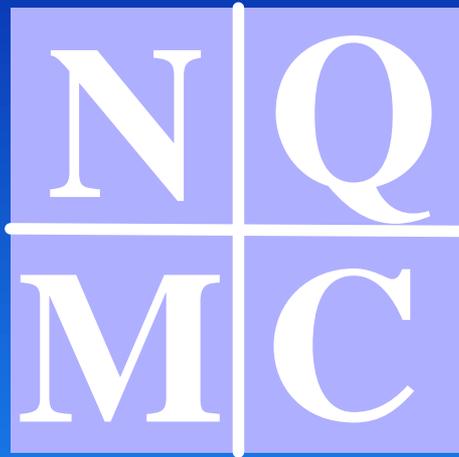


- Partnership with AMA and AAHP
- Structured abstracts, full text, comparisons
- Guidelines submitted by many groups



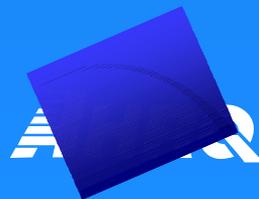


National Quality Measures Clearinghouse™



- **New Resource:** Online database of most current evidence-based quality measures and measure sets to evaluate and improve the quality of health care

www.qualitymeasures.ahrq.gov





AHRQ Quality Indicators (QIs)

3 Software Modules

■ Prevention QIs

Ambulatory care sensitive conditions

■ Inpatient QIs

Mortality for conditions and procedures

Utilization of procedures

Volume of procedures

■ Patient Safety Indicators*

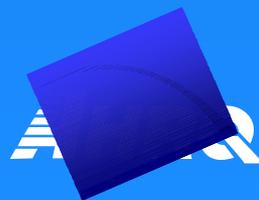
Post-operative complications

Iatrogenic conditions

Key Features:

- *Based on hospital discharge abstract data*
- *Use only data elements common to all systems*
- *No need for linking*
- *Designed as a screen for potential quality of care problems*
- *Support contract for QIs**

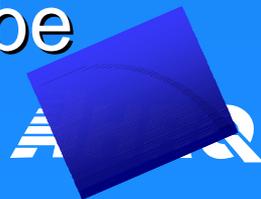
** available summer 2002*





Issues

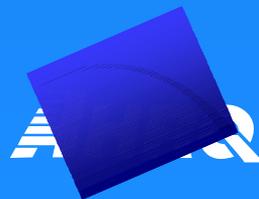
- Will public reporting → improvements?
- Literature to date suggests modest albeit growing impact on consumers' decisions
- Apparently tangible impact on providers
- Paying for quality – YES, but HOW??
- If quality improvement is local, what is federal role?
- Source of “legitimacy” for standards can be elusive



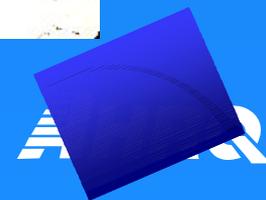
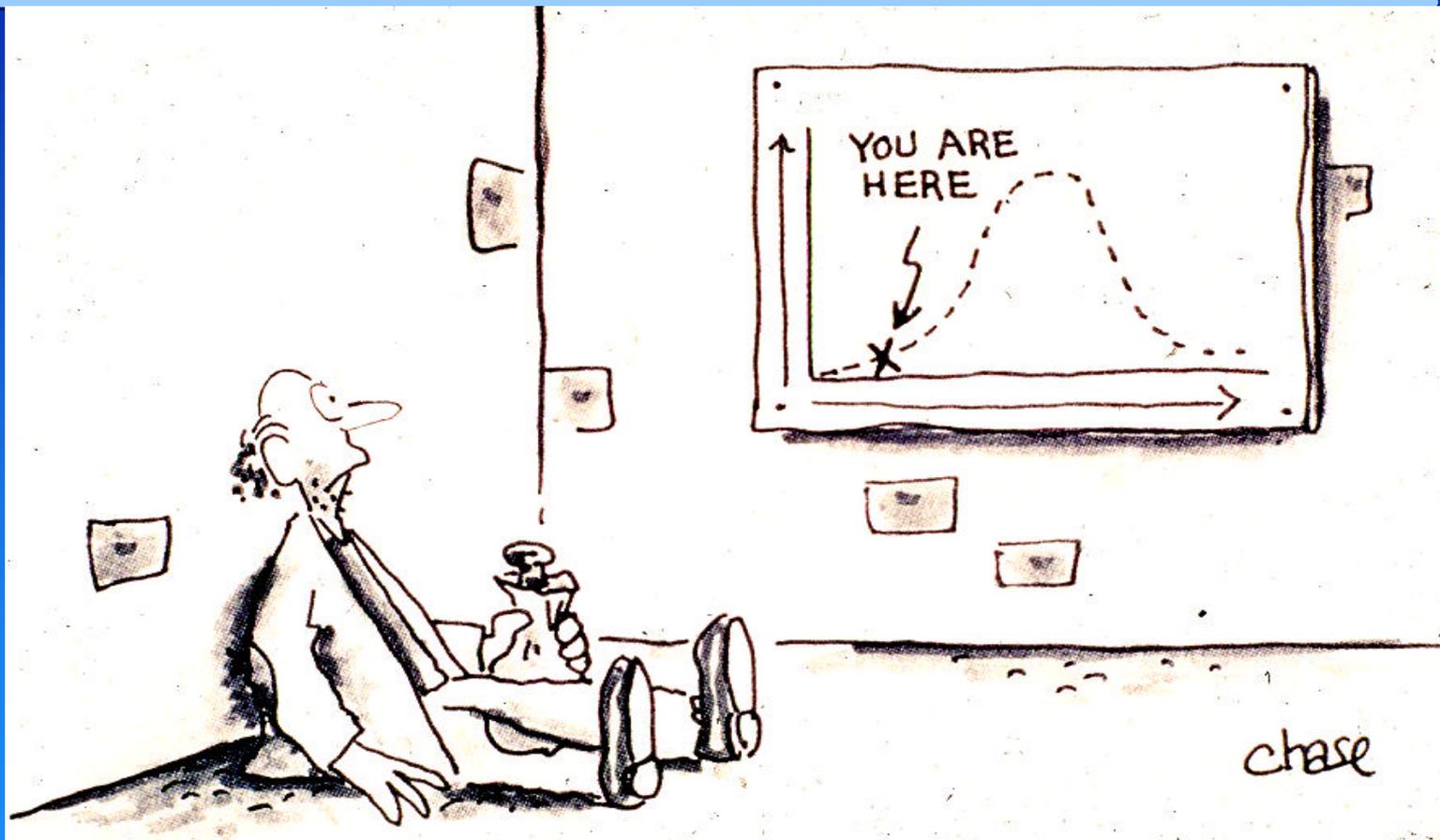


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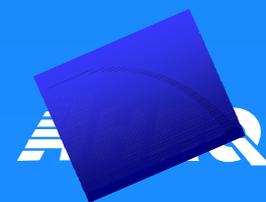
Where is US Health Care and IT?



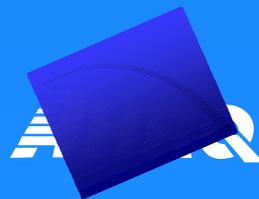
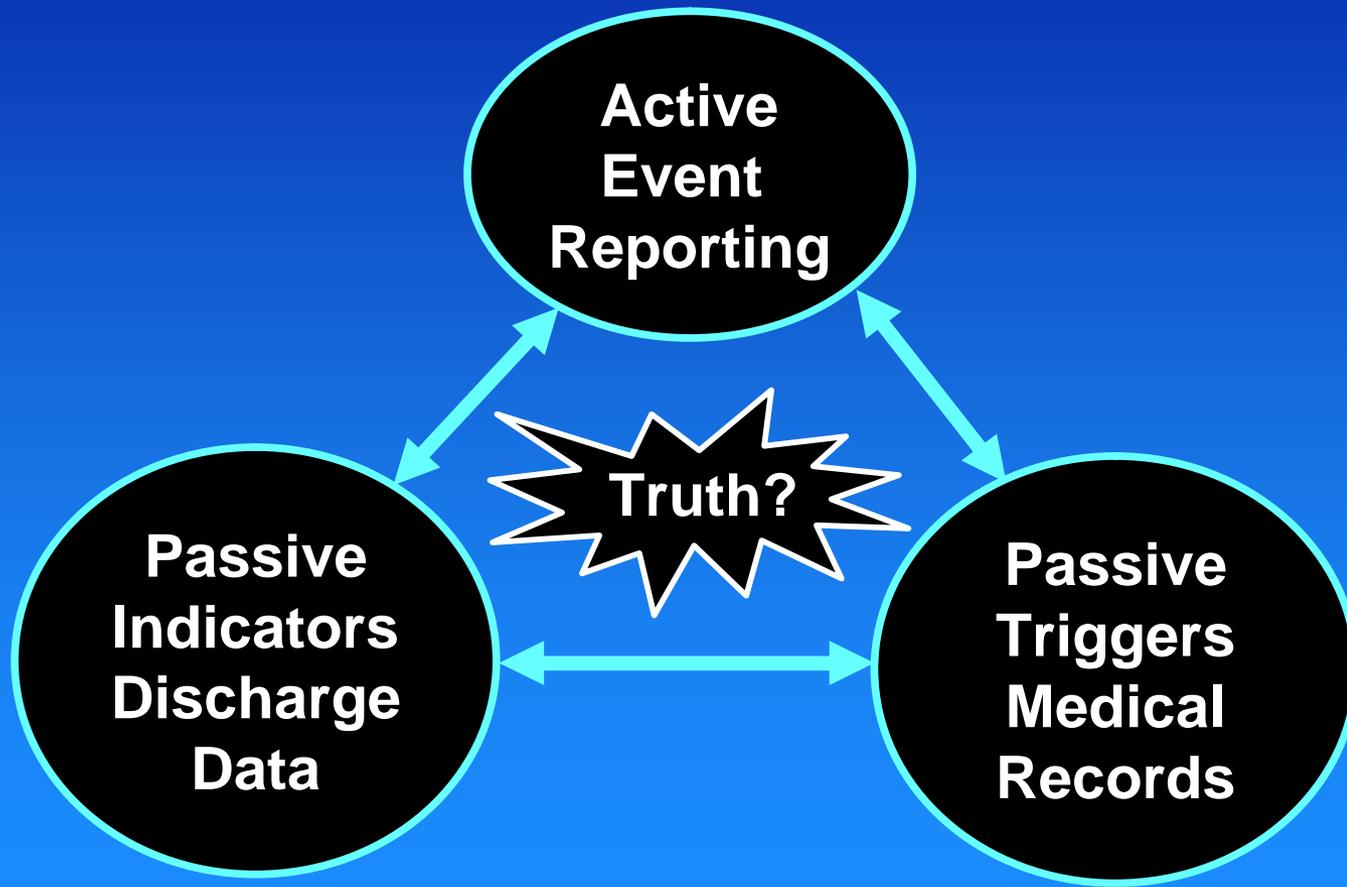


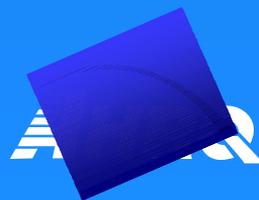
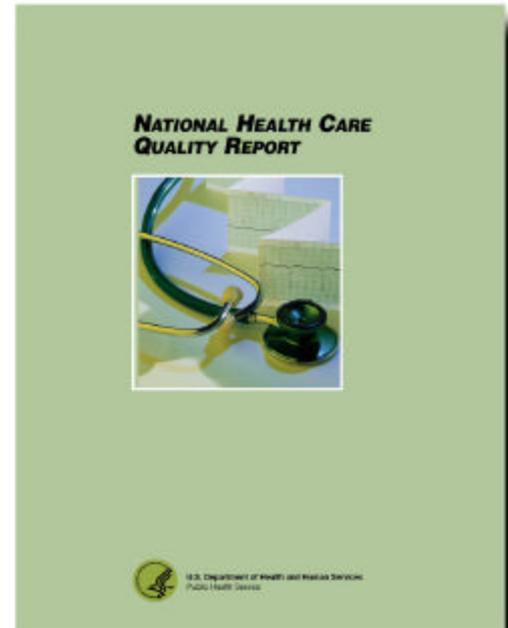
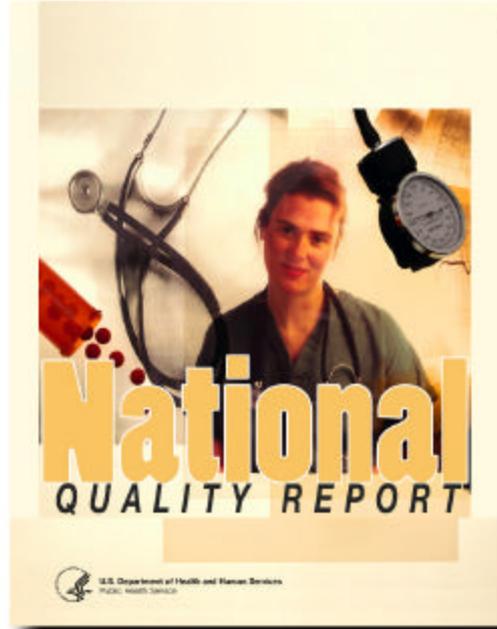
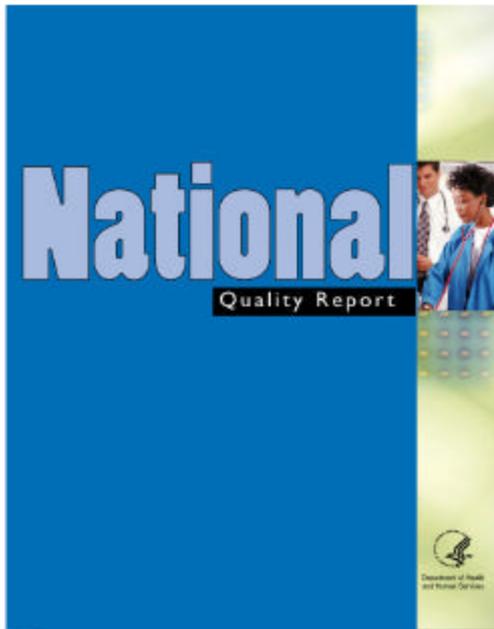
Potential of IT for Assessing Quality

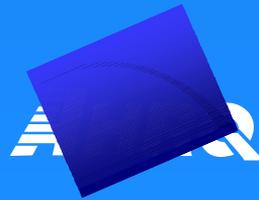
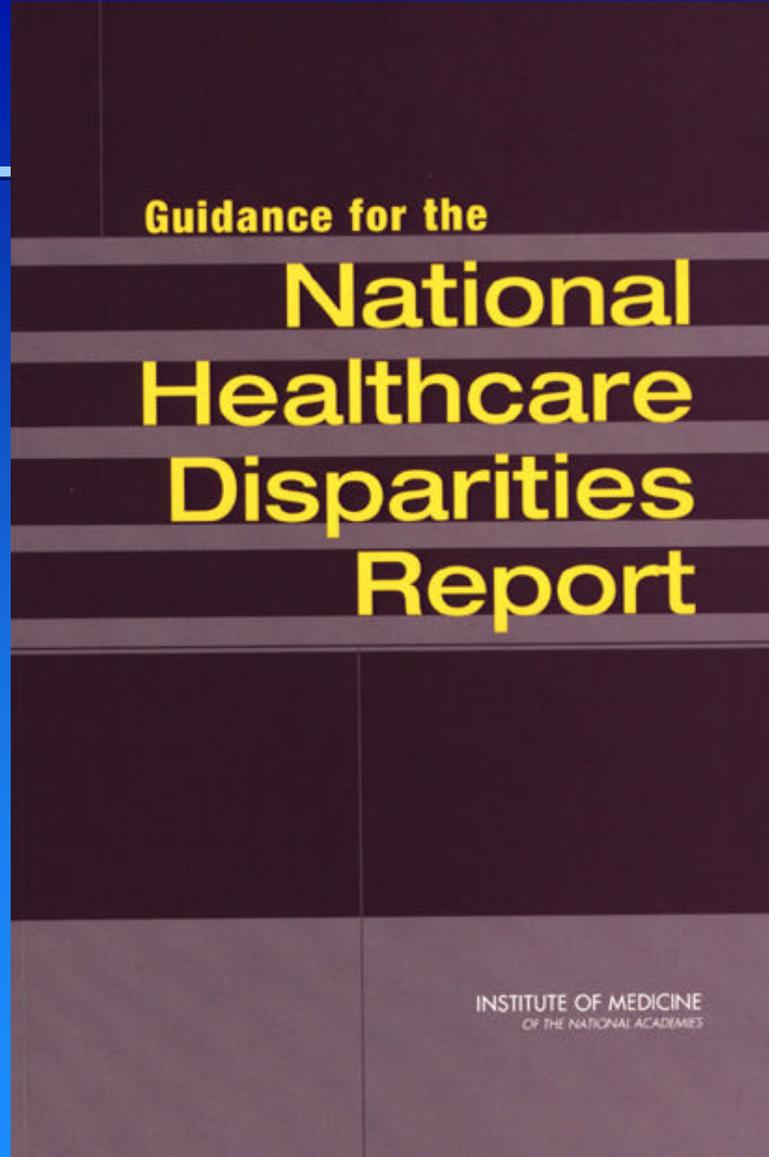
- IT can enhance the precision and decrease the cost of measurement – i.e., getting to the “right” measures
- IT can also enhance translation of strategies to improve quality (e.g., decision support)



Surveillance for Quality









Issues

- Will public reporting → improvements?
- Literature to date suggests modest albeit growing impact on consumers' decisions
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- Paying for quality – YES, but HOW??
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