



*Statement Before the*

**Subcommittee on Health Care  
Committee on Finance  
United States Senate**

**What is Health Care Quality and Who  
Decides?**

*Statement of*

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Mr. Chairman, thank you for giving me the opportunity to address the Subcommittee on the very timely and important issue of health care quality. I ask that my full statement be made part of the official record.

The mission of the Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of Health and Human Services (HHS), is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency fulfills this mission by developing evidence and working with the health care system to utilize information that:

- Reduces the risk of harm from health care services by using evidence-based research and technology to promote the delivery of the best possible care;
- Transforms the practice of health care to achieve wider access to effective services and reduce unnecessary health care costs; and
- Improves health care outcomes by encouraging providers, consumers, and patients to use evidence-based information to make informed treatment decisions.

Ultimately, AHRQ's goal is to improve the quality and safety of health care. It achieves this goal by developing evidence about which interventions are most effective, developing quality measures, working with frontline clinicians, health care organizations, and health care leaders, and through close collaborations with the Centers for Medicare and Medicaid Services (CMS) and other HHS operating divisions. AHRQ provides clinicians, patients, and other stakeholders with evidence-based "best practices" and quality measures through its support of the National Guideline Clearinghouse and National Quality Measures Clearinghouse.

## **What is Quality?**

Simply put, health care quality is getting the right care to the right patient at the right time – every time.

There are three basic dimensions to this: structure, process, and outcome. Structure represents the basic characteristics of physicians, hospitals, other professionals, and other facilities. It describes whether there are well-educated health professionals, appropriate hospitals, nursing homes, and clinics, as well as well-maintained medical records and good mechanisms for communication between clinicians. For example: Is the mammography equipment up to date and maintained properly? Are the cardiologists well-trained and board certified?

If the structure is solid, we can concern ourselves with the process of medical care. Concern for process suggests that quality is determined not just by having the right people and facilities available, but also by having the right things get

done in the right way. Process includes questions like: Was the mammogram done for a woman at risk for breast cancer? Was the heart attack treated in the most up-to-date manner?

The third dimension, outcome, reflects the end result of care. Did people get better? What was the risk-adjusted mortality rate? Was disease or disability reduced or prevented? Was it reduced as much as it could have been, given what we know is scientifically possible? We need to be able to measure the outcomes of care so that we know which types of care really help patients and so that we can look to instances of poor outcome for opportunities for improvement.

Together, these components are the foundation of providing care that is consistently safe, timely, effective, efficient, equitable, and patient-centered. (IOM 2001)

### **Quality Today**

The U.S. leads the world in biomedical advances and innovation. However, we do far less well in getting the right care to the right patient at the right time consistently. Moreover, the U.S. spends far more than any other nation, yet numerous studies have found that there is no relationship between high spending and care quality.

This is borne out by AHRQ data.

AHRQ is required to report to the Congress annually on the state of quality in the nation. Last year, according to statistics from AHRQ's 2007 *National Healthcare Quality Report (NHQR)*, the U.S. health care system continues to face challenges in improving the safety and quality of health care, ensuring access to care, increasing value for health care, and reducing disparities associated with patients' race, ethnicity, income, education, or place of residence.

The *National Healthcare Quality Report* tracks the health care system through quality measures, such as what proportion of heart attack patients received recommended care when they reached the hospital, or what percentage of children received recommended vaccinations. The Report is based on a framework established by the Institute of Medicine and is developed working with an interagency working group within HHS. It includes more than 100 measures culled from a wide-range of existing public- and private-sector data collection effort.

Overall, the quality of health care as measured by the quality indicators in our report improved by an average of 1.5 percent per year between the years 2000 and 2005, although this represents a decline when compared with the 2.3 percent average annual rate between 1994 and 2005. Quality indicators in some

areas have improved, such as the percentage of patients who are counseled to quit smoking. For example, the percentage of patients receiving recommended care after a heart attack has increased more than 15 percent between 2002 and 2006. However, measures of patient safety, such as appropriate timing of antibiotics received by adult patients having surgery and inappropriate medication use by the elderly, showed an average annual improvement of 1 percent. In addition, the report reflects larger improvements associated with public reporting by providers of performance.

There has been some progress in reducing care disparities. For example, the disparity between the rates of black and white hemodialysis patients who receive adequate dialysis has been eliminated, and disparities in childhood vaccinations rates for different racial groups have been reduced. However, the most recent National Healthcare Disparities Report (NHDR), AHRQ's companion report to the NHQR, shows that most disparities in health care quality *and* access are either staying the same or actually getting worse. The NHDR showed that more than 60 percent of disparities in measures of quality have stayed the same or worsened for Blacks, Asians, and poor populations. Also, nearly 60 percent of disparities have stayed the same or worsened for Hispanics.

Quality problems have implications beyond health. A July 2008 AHRQ study found that potentially preventable medical errors that occur during or after surgery may cost employers nearly \$1.5 billion a year ("Impact of Medical Errors on 90-Day Costs and Outcomes: An Examination of Surgical Patients," in the July 2008 issue of *Health Services Research*). Care for surgery patients who experienced acute respiratory failure or post-operative infections increased the cost of their care by 100 percent! The authors also concluded that studies which focus only on medical errors that occur during the initial hospital stay may underestimate the financial impact of patient safety events by up to 30 percent.

Measures of health care quality averaged over the U.S. population are not a substitute for the daily reality faced by every health care provider and patient in clinics and hospitals. At the same time, statistics reflect the aggregated everyday experiences of patients and their doctors and nurses across the Nation. It makes a difference in people's lives when breast cancer is diagnosed early with timely mammography; when a patient suffering from a heart attack is given the correct lifesaving treatment in a timely fashion; when medications are correctly administered; and when doctors listen to their patients and their families, show them respect, and answer their questions.

Yet reports do not improve quality by themselves. Findings need to be disseminated and awareness raised. Providers need to be trained. Community partnerships that bring together all the stakeholders that can make or break a quality improvement initiative need to be created and maintained. Building on information contained in the AHRQ quality and disparities reports, HHS

organizations are implementing an exciting range of programs that address health care quality nationwide.

There is good news. Today, we have a window of opportunity made possible by all of the attention that is being paid to changing the health care system. We need to be more engaged and aggressive and completely committed to transforming the health care system, because what we are doing clearly is still not good enough.

The President has taken advantage of this opportunity by emphasizing quality as a key element of health reform. His budget blueprint names improving patient safety and quality as one of the eight principles to guide the development of a health reform plan. Its proposals include building quality into Medicare payment systems. And the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. 111-5, includes significant investments in health information technology (health IT), comparative effectiveness research, and prevention – all of which have enormous potential to improve the structure, process, and outcomes of our health system.

### **Accelerating Improvement**

As attention has shifted from documenting that health care organizations and clinicians have the right equipment and training to deliver excellent care (structure), to assessing whether that competence is reflected in day-to-day care (process and outcomes), it has become clear that performance is often less than ideal. That is because we have not yet designed systems to make the right thing the easy thing to do. For example, a landmark study from RAND in 2003 found that Americans receive recommended care 55 percent of the time.

In the past decade, we have made enormous strides in developing and implementing scientifically based measures of quality that reflect current science as well as patients' experiences. The National Quality Forum, a private voluntary consensus organization, now endorses quality measures through a transparent process involving clinicians, hospitals, health plans, employers, and patients. Private and public sector purchasers increasingly require use of these measures in their contracts and are linking performance to financial rewards. Health care professional organizations have developed strategies to link engagement in quality improvement initiatives with continuing education and specialty certification, rather than assuming that superb knowledge automatically results in excellent care. Accrediting bodies have also incorporated these measures into their programs.

As a result of focusing on actual performance and transparency, we can now see clearly where improvements are needed. While biomedical innovations mean that health care is often far better than it was 10 years ago, we also need innovations in care delivery to accelerate the pace of improvement. Translating

scientific advances into better care for all requires the capacity for making that information available to clinicians and patients when care is delivered, and incentives and infrastructure to make this achievable.

Accelerating improvements is essential to sustainable health care reform. Effective partnerships between the public and private sectors that engage the commitment and energy of clinicians, patients, health care leaders, and payers are indispensable. Most economists believe that payment reforms that reward quality and value rather than volume are also essential. Today I want to focus on specific infrastructure components that form the essential foundation for consistently excellent care: widespread effective use of health IT; uniformity of measurement approaches across payers; focus on high-impact opportunities; and a commitment to linking quality improvements with eliminating disparities.

**Health IT** Health IT is the foundation that supports quality measurement and improvement, care coordination, and provides clinicians and patients the information necessary to optimize care. Data collection to assess quality has traditionally been based largely on chart reviews, use of billing claims with insufficient clinical detail, and patient surveys. This infrastructure is laborious and incapable of supporting timely feedback to clinicians providing care. Moreover, quality improvement and assessment initiatives have been almost exclusively setting-specific, thereby bypassing important opportunities to improve care, such as care transitions between settings. Widespread adoption of electronic health records, personal health records, and other health IT applications could reduce the burden of data collection and provide a platform for providing the right care to the right patient at the right time – every time. The “right care” includes performance measures as well as information that helps clinicians coordinate care effectively. Moreover, enhanced efficiency of data retrieval and collection can serve multiple purposes, including assessment of adverse drug events, evaluation of the comparative effectiveness of alternative treatments, and monitoring for public health emergencies.

**Uniform Measures** We understand and appreciate that the health care system faces a data burden imposed by both the public and private sectors. Today physicians and hospitals face multiple demands for quality information from payers, accrediting bodies, States, and purchasers. Disparate requirements too often add administrative burdens and disrupt workflow without enhancing patient care. In addition, physicians have expressed concern that some measures may have the unintended consequence of discouraging physicians from seeing sicker patients, as well as worsening disparities.

Since 2004 a multi-stakeholder, collaborative approach to measure development and consistency in their use has resulted in nearly all U.S. hospitals now reporting on the same measures to Hospital Compare, a Web site created by CMS and the Hospital Quality Alliance to give consumers the information necessary to compare their local hospitals on dozens of quality measures,

procedures, and the patients' perspectives on their care. This cooperation helps set the stage for value-based purchasing by both public and private sector purchasers. Similar efforts have been established for nursing home, home health, and dialysis facility performance. These efforts provide a foundation for rapid progress toward providing meaningful information that patients can use to make decisions and that clinicians can use to improve care. In short, the goal should not be only additional measures – but better information.

Collaboration among Federal Government agencies is also important to achieve uniformity in measurement and quality. We work together closely to ensure that the health care services that we provide and purchase are safe and of high quality, and that Americans have science-based information to make informed health care decisions.

The bottom line is that improving health care quality is not the sole responsibility of government or of the private sector. Public-private partnerships to develop and use measures that guide progress toward high-quality, affordable care are essential. Because quality is ultimately very personal, these partnerships have included and must continue to include all perspectives, especially those of consumers and patients. Patients and families see problems from a personal perspective and may observe deficiencies that busy providers do not or cannot notice. They are uniquely situated to detect flaws during transitions of care and to experience the effects of inadequate care coordination.

### ***High-impact Opportunities***

Focus on Chronic Illness Increased longevity and advances in effective treatment of previously lethal diseases have resulted in steady increases in the proportion of Americans suffering from chronic illnesses. These illnesses are rarely isolated; for example, AHRQ data show that just under 10 percent of adults with diabetes have only that condition – the majority have one or more additional conditions. Individuals with multiple chronic illnesses comprise most of the 20 percent of adults whose needs account for over 70 percent of spending. Quality reporting efforts have resulted in important improvements; for example, the proportion of people with diabetes who receive appropriate testing for control of their disease and associated risk factors has increased significantly. Those process improvements, however, have not yet resulted in significant improvements in near-term outcomes, in part because changing outcomes requires a sustained effort beyond the clinical care.

Within the past 2 years, based on findings from the 2006 *National Healthcare Disparities Report*, HHS agencies (AHRQ, CMS, the Administration on Aging, and the Centers for Disease Control and Prevention) collaborated to reduce disparities for Hispanic elders in 8 metropolitan communities, with a focus on diabetes and preventive care. The combination of data to identify the patients at highest need and effective collaboration with community partners to assist

individuals with managing their conditions enabled communities to maximize the impact of chronic disease self-management programs. The enhanced approach to patient self-management is now being adapted in Medicare reimbursement for diabetes education.

Quality Care for America's Children The reauthorization of the Children's Health Insurance Program (CHIP) is the most recent example of a high-impact opportunity to advance care quality. The law (Pub. L. 111-3) provides \$45 million in each of 5 years to carry out several quality improvement provisions. These provisions are particularly important because many low-income children move frequently between Medicaid, CHIP, and private sector coverage, and because a focus on children has not been a substantial part of recent quality efforts. We look forward to working closely with CMS, States and all stakeholders on these initiatives to assure that all children receive high quality care.

***Inequality in Quality*** Studies or reports on quality share two common findings, irrespective of focus or location: (1) a substantial gap between best possible and actual care; and (2) an even larger gap for members of racial and ethnic minority groups, the poor, those with limited education, and those in remote areas. The tools and data to improve care quality can be used simultaneously to improve care and reduce disparities. In some instances, a focused approach to quality improvement has resulted in improvements for all, such as those with end-stage renal disease. In other areas, we urgently need to learn how to close the gaps effectively for subgroups at the highest risk of poor quality. The Commonwealth of Massachusetts will require reporting on quality and disparities in 2010, and other States are exploring similar approaches. The Institute of Medicine will make recommendations regarding a voluntary standard approach for combined reporting of quality and disparities later this year.

## **Future Directions**

Lessons from quality improvement initiatives in other sectors, such as manufacturing and transportation, are reminders that there is no quick fix or easy overall remedy. Instead, it seems clear that quality improvement in health care, as in other sectors, requires a coordinated, deliberate, consistent, and sustained approach. It is important to recognize that health care quality is improving, but this improvement is happening slowly. Resources provided by ARRA for health IT, comparative effectiveness research, and prevention should accelerate the achievement of consistently high quality care.

Addressing health care issues involving people with chronic illnesses can take us a long way in our efforts to change the system. Consumer engagement and the involvement of patients and their families in health care are critical. Recognition of the importance of comparative effectiveness in evaluating various drugs, devices, and treatments; publicizing which work best and at what cost; and



making that information useful and relevant for patients, caregivers, and clinicians will be enormously important.

Improved quality and value need not cost more. Studies from Dartmouth have consistently found that areas with the highest Medicare spending are often associated with inferior, rather than better quality, care. We need to ensure that we are basing our quality improvement efforts on good science, the best data, and effective collaboration. High quality and affordable care can, and should be, one and the same. For this reason, quality is central to the President's health reform effort.

Mr. Chairman, we have begun to make progress toward creating a high-quality, safe health care system. The ultimate answer to the question "Who Decides?" will be provided by patients and all stakeholders in health care. The Federal Government can convene stakeholders and provide leadership and guidance, but this has to be a collaborative effort to succeed. Don Berwick, a nationally renowned quality expert, once observed that "In the end, only those who provide care can improve that care." Accelerating the pace of improvement can and must be guided at all times by the needs of clinicians and patients. With the recent comparative effectiveness funding in ARRA, a critical investment was made to determine what care works best for which patients. We must strive to capitalize on this investment and share the results, so all stakeholders in health care can decide how best to use the information. Finally, we must increasingly focus on measuring the value of results achieved in health care and how to enable and reward the delivery of evidence-based care. We know much of what to do to improve health care, we now must work together to put it into action. Thank you.