As President and CEO of AcademyHealth—the professional society for the field of health services research and health policy—I am pleased to present *AHRQ: 15 Years of Transforming Care and Improving Health* on behalf of the Friends of AHRQ. This report celebrates the contributions of the Agency for Healthcare Research and Quality (AHRQ) to improve health and health care and commemorates the agency’s 15th anniversary.

Research, datasets, and tools supported by AHRQ are used by patients; physicians, nurses, and other health care providers; health systems and hospitals; public health professionals; federal, state, and local policymakers; and purchasers and payers, such as employers and public and private insurers to make health care safer; of higher quality; more accessible, equitable, and affordable; and to ensure that this evidence is understood and used.

In the pages that follow, some of the producers and users of AHRQ’s work reflect on the agency’s last 15 years and explain the ways in which AHRQ has helped them transform health care and public health services. In reading their stories, I am reminded of my own experiences with AHRQ and its predecessor agencies over the last 22 years—as a pediatrician, a public health professional, an AHRQ-funded trainee, a researcher, a patient, a caregiver, and even as the agency’s deputy from 1996-2002. The agency and its health services research have transformed my life—personally and professionally—and I believe its work is vital to improving the health and health care of Americans now, and for generations to come.

The health services research supported by AHRQ helps us understand and improve a complex and costly health care system so that we can achieve better outcomes for more people at greater value. It is important work that must continue.

Sincerely,

Lisa Simpson, MB, BCh, MPH, FAAP
President & CEO, AcademyHealth
According to the Congressional Research Service, the federal government spent more than $140 billion on all research in fiscal year 2011.\(^1\) Health research sponsored by the Department of Health and Human Services (HHS) represented nearly a quarter of this total, making HHS the nation’s second largest federal research funder, behind the Department of Defense.

The federal government has a longstanding role in supporting the health research continuum and establishing foundational knowledge. In the same way the federal government built the interstate highway system from which all Americans benefit, the government supports health research that would not occur in the private marketplace alone and offers benefits to the nation as a whole. As highways are an engine for commerce, development, and expansion, health research is an engine for increased productivity, innovation, and value.

“\textit{In this new age of enlightenment about our nation’s fiscal well-being, health services research may be on the verge of a renaissance as policymakers, payers, providers, and patients look for answers to hard questions about the availability, quality, and costs of health care.}”

\textit{– Dr. Joseph Antos, American Enterprise Institute, Washington, DC}
The federal government supports different and equally necessary types of health research across a continuum in universities, medical centers, state and local health departments, and businesses across the nation.

**Basic research** increases our knowledge about how living organisms work and what causes disease.

Once we know how a disease works through basic research, **clinical research** determines how to prevent and treat that disease in people. Federally-funded clinical research provides the basis for drug and device development in the private sector.

**Population-based research** (public health research) studies how to improve the health of the population by addressing and preventing injury, illness, and disease through non-medical means in communities where people live, work, learn, and play.

Once we have the treatments and interventions in hand, **health services research** determines how to best deploy them. Health services research improves our understanding about what works, for whom, in what settings, under what circumstances, and at what cost. It studies how our health system works, how to support patients and providers in choosing the right care, and how to improve health through care delivery. Findings from health services research have helped make care safer, more effective, and more affordable.

**Translational research** studies how best to move evidence across the research continuum, from the lab bench to the patient’s bedside, and from there to the “curbside” – communities where patients and their families live, learn, work, and play. The faster the uptake of credible evidence, the quicker health care and health may improve, and the greater the returns on the nation’s research investment.
These components of the research continuum work in concert, and each plays an essential role—any one type of research on its own cannot effectively or appreciably improve health. **Take heart disease as one example...**

**Basic research**
- discovered the contributions of elevated blood pressure, elevated cholesterol, and tobacco use to heart disease.

**Clinical research**
- determined which treatments were safe and effective to treat hypertension, hypercholesterolemia, tobacco addiction, and to prevent and treat heart disease, in general.

**Population-based research**
- identified strategies to reduce the risks of heart disease in communities through non-medical interventions, such as reduction of trans fats in food and tobacco control measures to reduce smoking.

**Health services research**
- determined how to best deploy these interventions to different groups of patients and populations to achieve the best outcomes. This research helped identify who had the least access to the interventions and what barriers to access existed, as well as how to mitigate them. Health services research also led to the development of quality measures that are now used throughout health care to report on the quality of cardiac care.
Health Services Research: Discovering Health System Improvements

The United States spent $2.7 trillion—nearly 18 percent of our economy or GDP—on health care in 2011. Finding new ways to get the most out of every health care dollar is critical to our nation’s long-term fiscal health. Like any corporation making sure it is developing and providing high quality products, the federal government—as the nation’s largest health care purchaser—has a responsibility to get the most value out of every taxpayer dollar it spends on Medicare, Medicaid, the Children’s Health Insurance Program, and veterans’ and service members’ health.

Health services research is our nation’s R&D enterprise for health improvement. As medical research discovers cures for disease, health services research discovers cures for the health system. This research diagnoses problems in health care and public health delivery and identifies solutions to improve outcomes for more people, at greater value. And while biomedical and clinical research discoveries can take years and even decades to materialize, discoveries from health services research can be used now to improve care today.

“... The federal government is facing major budget deficits, and about two-thirds of outlays track back to health care delivery. Health services research could help close the fiscal gap, understanding how to eliminate the 35-50 percent of spending that is waste. The feds shouldn’t just be interested in health services research; they should be vested in it.”

– Dr. Brent James, Intermountain Healthcare, Salt Lake City, Utah

The Cost of Health Care: How much is waste?
In 2009, $2.5 trillion was spent on health care in the United States. Thirty percent, or $765 billion, was waste. Of the $765 billion in waste ...

Unnecessary Services $210 Billion
Excessive Administrative Cost $190 Billion
 Prices That Are Too High $105 Billion
Fraud $75 Billion
Inefficiently Delivered Services $130 Billion
Missed Prevention Opportunities $55 Billion

Source: Institute of Medicine, 2011

= $1 Billion
**Thanks to health services research, we know that health care sometimes falls short...**

- In 1999, the Institute of Medicine estimated that 44,000 – 98,000 Americans died in hospitals each year from preventable medical errors. In 2010, a nationwide study found that one in seven Medicare patients suffered harm from hospital care and another study in 2011 found that the rate of adverse events in hospitals could be as high as one-third of all admissions.³
- An estimated 1.7 million hospital-acquired infections occur each year, leading to about 100,000 deaths.⁴
- Patients do not receive the care recommended for them by evidence. For example, patients with diabetes receive recommended preventive care only 21 percent of the time.
- Health care is increasingly complex, and for patients with multiple chronic conditions poor coordination results in unnecessary tests, hospitalization, and readmissions. One study found that almost one-fifth of Medicare patients were re-hospitalized within 30 days.⁵
- Care varies by income, race, and geography. For example, individuals with lower incomes received lower quality care on 80 percent of national core quality measures.

**Thanks to health services research, we know that falling short costs money...**

- In 2008, costs attributable to medical errors were estimated at $19.5 billion—more than half of the National Institutes of Health’s annual budget.⁶
- Medication errors alone cost as much as $2 billion each year—equivalent to the federal government’s annual investment in health services research.⁷
- The average cost of care for a patient with a catheter-related blood stream infection is $45,000, costing up to $2.3 billion annually nationwide.⁸
- Medicare spends $12 billion a year on preventable hospital readmissions—more than double the discretionary budget of the Centers for Disease Control and Prevention.⁹
- The Institute of Medicine recently estimated that the total amount of unnecessary health care costs and waste in 2009 exceeded $750 billion, more than one-third of total health care expenditures.¹⁰

**Thanks to health services research, we know how to do better...**

- Reporting on the quality of care in hospitals leads to decreased patient mortality and reporting on nursing home quality shows improvements in pain management, reductions in pressure ulcers, and improved patient and family satisfaction.¹¹
- Achieving a patient centered medical home enhances patient care experiences, decreases the use of the emergency department by older adults, and improves the delivery of preventive services.¹²
- Implementation of computerized physician order entry could prevent between 570,000 and 907,000 serious medication errors each year.¹³
- Quality improvement approaches, including improved primary care, discharge planning, and follow-up care can prevent or reduce hospitalizations and rehospitalizations that cost Medicare $12 billion each year.¹⁴
- Systematic reviews of adverse events have been instrumental in improving health care safety and the well-being of patients. For example, a report documenting the adverse events related to ephedra was instrumental in the withdrawal of the substance after a well-known baseball player died after using it.¹⁵ Another report documented the potential harmful side effects of atypical antipsychotics in the elderly, which led to a new FDA black box warning.¹⁶
For more than 40 years, the federal government has funded health services research to understand how to improve the quality and value of health care and public health delivery. In 1999, Congress enacted the Healthcare Research and Quality Act establishing the Agency for Healthcare Research and Quality in HHS as the only federal research agency with the sole purpose of producing evidence to make health care safer; higher quality; more accessible, equitable, and affordable; and to ensure that the evidence is understood and used. As such, AHRQ funds health services research and health care improvement programs in universities, medical centers, research institutions, and medical practices that are transforming people’s health and health care in communities in every state.

“The research that AHRQ supports sits at a critical intersection—generating evidence to support the needs of delivery systems dedicated to achieving the highest possible quality, and the needs of consumers and purchasers to understand the actual performance of the delivery system they are supporting.”

– Dr. Reed Tuckson, Tuckson Health Connections, Edina, Minnesota

AHRQ Across the Ages

AHRQ in its current incarnation has been around only 15 years. However, it has a long history of providing crucial evidence to improve health and health care. Dr. Louis F. Rossiter—distinguished health economist, professor at The College of William & Mary, and former Secretary of Health and Human Resources for the Commonwealth of Virginia—reflects on AHRQ’s history and his role in it.

When the feds created Medicare and Medicaid in 1966, the National Center for Health Services Research was established because there were so many questions to be answered on how to effectively run these new major entitlement programs. How do you pay physicians? How do you organize care? And when President Ronald Reagan took office in January 1981, he immediately started asking questions about how to make these programs more competitive. NCHSR was there to help answer those questions.

I was there at the time, and I was charged with leading research on competition in financing and delivery of the health system. The body of work the agency produced was at the leading edge of the competition movement, and provided the seeds of the Medicare Health Maintenance Organization (HMO) program. Would we have Medicare Advantage today without AHRQ’s early work…If AHRQ hadn’t been studying [these issues], because Reagan cared about the role of competition in the health sector?

Another of the agency’s major accomplishments has been the Medical Expenditure Panel Survey or MEPS—the only source of household information on the use and costs of health care services. MEPS has been used to count and measure the insured and uninsured, their characteristics, their service use and costs. There’s no other dataset like it. In fact, if you look at every major health policy change since 1977—and almost every administration has had one—MEPS has been used to model and predict effects.

Later, as Virginia Secretary of Health and Human and Human Resources from 1999-2002, we used research from AHRQ all the time, especially for our Medicaid program and its costly long-term care component. AHRQ funded a lot of research on how to restructure long-term care payments. In Virginia, we reformed our payment systems based on this research, decoupling payments from nursing home costs and encouraging nursing homes to be more efficient.
Over the years, AHRQ’s research portfolio has coalesced around four broad themes, all of which are designed to improve the quality and value of health care and public health service delivery:

Making care more accessible, with a focus on insurance coverage, the health care workforce, and disparities in care based on race, gender, and geography.

Making care safer, with a focus on preventing health care-associated infections and reducing other harms associated with care, such as medical errors.

Making care more effective, with a focus on disseminating evidence to health care providers.

Making care more efficient, with a focus on health care and public health financing, organization, and delivery.

As a science agency, AHRQ is also responsible for sustaining and modernizing the research infrastructure—data, methods, and human capital—needed to produce health services research in response to a rapidly evolving health care environment, emerging technologies and innovative data sources, and the changing needs of health care decision makers in the public and private sectors.

The following examples of research, projects, tools, and datasets funded by AHRQ provide a snapshot of the agency’s role in generating and disseminating evidence to support better health care:

- The evidence-based Comprehensive Unit-based Safety Program to Prevent Healthcare-Associated Infections (HAI) or CUSP funded by AHRQ, which was first applied on a large scale in 2003 across more than 100 intensive care units (ICUs) across Michigan, saved more than 1,500 lives and nearly $200 million in the program’s first 18 months. With subsequent AHRQ funding, the program has been spread to hospitals in all 50 states, the District of Columbia, and Puerto Rico to continue the national implementation of this approach for reducing HAI.

- With funding support from AHRQ, the University of California, San Diego Medical Center and Emory University Hospitals partnered to develop an evidence-based toolkit for health care providers on preventing venous thromboembolism. This lethal disorder affects hospitalized and non-hospitalized patients, recurs frequently, and is often overlooked. Health care providers in Idaho, Indiana, Kentucky, New York, North Carolina, South Carolina, and Washington are now using the toolkit to prevent dangerous blood clots.

- The explosion of new knowledge and the growing complexity of care make it challenging for doctors and nurses to keep up. Over the last 15 years, AHRQ’s Evidence-based Practice Centers have enabled countless providers and professional associations to improve care based on the best available evidence.

- More than a quarter of all Americans—and two out of three older Americans—are estimated to have at least two chronic physical or behavioral health problems. Treatment for people living with these multiple chronic conditions (MCC) such as diabetes and heart disease currently accounts for an estimated 66 percent of the nation’s health
care costs—and these costs are projected to rise. As a scientific partner in primary care improvement, AHRQ’s *Multiple Chronic Conditions Research Network* generates evidence on how best to improve care for people with MCCs and to engage patients in managing their treatment.¹⁷

- When Congress established the Children’s Health Insurance Program, AHRQ funded research grants to study the impact of expanding coverage to low-income, working families. Researchers around the country found that coverage and access to care improved for enrollees, contributing to more preventive care, better care for children with chronic conditions, and a reduction in disparities among children.

- The *Medical Expenditure Panel Survey* (MEPS), supported by AHRQ, is the only national source for comprehensive data on Americans’ access, use, expenses, insurance coverage, sources of payment, and health care quality. MEPS data are used for measuring health expenditures as a share of America’s Gross Domestic Product, or GDP.

- AHRQ’s congressionally mandated *National Healthcare Quality Report* and *National Healthcare Disparities Report* are the only comprehensive sources of information on the status of health care quality and disparities among racial and ethnic minorities, women, children, low-income populations, and people with special health care needs.

- AHRQ is home to the *National Guidelines Clearinghouse* (NCG) and *National Quality Measurement Clearinghouse* (NQMC). The NCG provides physicians and other health care providers, health plans, delivery systems, and purchasers an online, comprehensive and easy to use repository of objective, detailed information on evidence-based clinical practice guidelines. The NQMC provides these users with an accessible resource for quality measures and a one-stop-shop for benchmarks on providing more safe, effective, and timely care. The breadth of evidence available from AHRQ empowers health care providers to understand not just how they compare to their peers, but also how to improve their performance to be more competitive.

“As a science agency, AHRQ is also responsible for sustaining and modernizing the research infrastructure—data, methods, and human capital—needed to produce health services research in response to a rapidly evolving health care environment, emerging technologies and innovative data sources, and the changing needs of health care decision makers in the public and private sectors.”
**Unique, But Not Alone**

AHRQ is the only federal agency that has a statutory charge to generate health services research that benefits *all* people, not just those with a specific condition or type of insurance coverage; to improve the quality and safety of care delivery in *all* settings; to improve the effectiveness of *all* care; and to understand the costs of, and expenditures for, *all* health care and public health services.

Because health services research offers valuable information for decision makers in the public and private sectors, there are other entities—inside and outside the federal government—producing and using evidence to improve health care and public health delivery according to their specific priorities and information needs. Within the federal government, these complementary research and dissemination activities are closely aligned with each agency’s specific mission. AHRQ effectively collaborates with each of the following research entities to best leverage the federal research investment.

| **NIH** | The National Institutes of Health (NIH) is the most well-known and the largest health research funder. Many of the Institutes and Centers within the NIH fund health services research on the specific clinical condition and/or organ they are charged with addressing in their missions (e.g., cancer or heart, lung, and blood). |
| **CDC** | The Centers for Disease Control and Prevention funds prevention research centers to improve the delivery of effective prevention services, both clinical and community preventive services. |
| **CMS** | The Centers for Medicare & Medicaid Services, including the new Center for Medicare and Medicaid Innovation (CMMI), funds demonstration programs to test and then spread evidence-based care improvement strategies for Medicare, Medicaid, and the Children's Health Insurance Program beneficiaries. CMS and CMMI fund evaluation studies which use health services research methods to measure the impact of these demonstrations on the populations covered by CMS. |
| **VA** | The U.S. Department of Veterans Affairs funds health services research specifically and solely on health care provided to veterans. |
| **DoD** | The Department of Defense funds health services research specifically and solely on health care provided to the military population through TRICARE. |
| **PCORI** | The Patient-Centered Outcomes Research Institute was established in 2010 as a nongovernmental entity to conduct comparative effectiveness research—a type of health services research. This research determines what treatments work best compared to other options. |

“NIH is great. CDC is great. But a lot of health services research doesn’t fit the NIH portfolio or CDC portfolio—patient safety, quality of care, efficiency of care—no one but AHRQ wants to touch these. If we lose AHRQ, numerous lines of important research fall through the cracks.”

— Dr. David Penson, Vanderbilt University Medical Center, Nashville, Tennessee
Imbalance in Health Care, R&D Spending

In 2011, the federal government spent $49.8 billion on health research—just 1.8 percent of the $2.7 trillion in national health care expenditures. Federal spending on health services research, which is essential in determining how to get more value from our health care dollar, was far less. AcademyHealth estimates that the federal government spends approximately $2 billion per year on health services research, representing just 4 percent of all health research spending and 0.074 percent of national health care expenditures. AHRQ’s budget is just a fraction of a fraction of health spending at roughly $430 million annually—less than 1 percent of all federally-funded health research, and just 0.016 percent of all health care spending.

“Government support of health services research is necessary to address collective, societal health issues such as rising health care costs, access to high-quality and affordable health care, and disparities in care.”

– Dr. Risa Lavizzo-Mourey, Robert Wood Johnson Foundation, Princeton, New Jersey

Health Services Research, AHRQ As A Share of Federal Health Research Spending, 2011

$ = $100 Million

“The benefits from investing in biomedical and clinical research fall far short of their full health potential because limited funding and attention go into health delivery and outcome-optimizing research… If patients are to receive the full benefit of medical advances, health care has to take health delivery research seriously…”

– Dr. Peter Pronovost, Johns Hopkins University School of Medicine, Baltimore, Maryland
Peter Pronovost, MD, PhD, FAAC, is a practicing critical care physician and serves as Senior Vice President of Patient Safety and Quality and Director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine. He is a world-renowned patient safety champion and health services researcher.

On a snowy night in February 2001, 18 month old Josie King was taken off life support and died in her mother’s arms at Johns Hopkins Hospital. She died from a cascade of errors that started with a central line-associated blood infection, or CLABSI. Each year, these preventable infections kill nearly as many people as breast cancer and prostate cancer.

Her mother Sorel asked her physician, Dr. Peter Pronovost, if her death could have been avoided. “We couldn’t give her an answer,” said Dr. Pronovost. “And she deserved one.”

At the time, as with most hospitals in the country, Johns Hopkins’ rates of infection were “sky high.” As Dr. Pronovost recalls, “I was one of those doctors putting in catheters and harming patients. No clinician wants to harm patients, but we were. So, we set out to change it.”

Dr. Pronovost and his team developed a program that included a checklist of best practices—a protocol he named the Comprehensive Unit-based Safety Program or CUSP. CUSP combines clinical best practices with an understanding of the science of safety and improves the culture where clinician teams are accountable for results. The program asked clinicians to review their infection rates and investigate every infection to learn how it could have been prevented. As Dr. Pronovost explained:

“We virtually eliminated these infections at Hopkins with CUSP. It worked because it was led by frontline doctors, nurses, and administrators working as part of a team, believing it was their problem, and knowing they were capable of solving it. It worked because it was informed by science, and it worked because it aligned many groups around a common measure with each doing their part to eliminate infections.

Dr. Pronovost wanted to see if the results were unique to Hopkins, or if CUSP could work elsewhere. So in 2003, with funding from AHRQ, Dr. Pronovost partnered with the Michigan Health and Hospital Association. Within six months, CLABSI were reduced by 66 percent in more than 100 Michigan ICUs. By the experiment’s end, 65 percent of Michigan ICUs went a full year without an infection.

With continued support from AHRQ and leadership from the American Hospital Association and many state hospital associations, the program has spread state-by-state to more than 1,100 hospitals. The program saved more than 1,500 lives and nearly $200 million in its first 18 months just in Michigan. “All from just an initial $500,000 investment from AHRQ,” said Dr. Pronovost.

“For the first time, we can confidently look Sorel King in the eye and say that patients like Josie are less likely to die at Hopkins, in Michigan, in Texas, and across the whole U.S.” said Dr. Pronovost. “This could be health care’s man on the moon moment. With these results, health care is taking a giant step forward. This program offers hope for us about what’s possible when policymakers invest in the science of safety.”

“If you want an ROI on our basic and clinical investments at NIH, you need AHRQ to improve care delivery so patients can benefit from the therapies that NIH discovered.”

Dr. Pronovost believes that the time has come for more health services research to improve quality and grow productivity in the health care system, and his team is using funding from AHRQ to build upon his success in fighting CLABSIs to reduce other harms, such as deadly ventilator-induced pneumonia and surgical complications. As he explains:

“We funded basic research. We funded clinical research. And now we have to look at how to best deliver it. We have a backlog of treatments—5,000 different drugs—that we don’t always deliver effectively. AHRQ and only AHRQ is responsible for research on how to do it. If you want an ROI on our basic and clinical investments at NIH, you need AHRQ to improve care delivery so patients can benefit from the therapies that NIH discovered.”
Collectively, more than 1,100 hospitals and 1,800 CUSP teams across 44 states, the District of Columbia, and Puerto Rico participated in a national initiative based on Dr. Pronovost’s research to eliminate CLABSIs (see map). In just 18 months, the rate of infection across intensive care units or ICUs decreased 41 percent and the number of ICUs and non-ICUs with zero infections for one quarter increased 38 percent. For more information about the CUSP initiative, please visit Dr. Pronovost’s Health Affairs blog post at: http://bit.ly/19Xkq5f
Using Data to Measure and Model Policy Change

Featuring: Dr. Stephen Parente, University of Minnesota, Minneapolis, Minnesota

Stephen T. Parente, PhD, MPH, MS, is the Minnesota Insurance Industry Chair of Health Finance in the Carlson School of Management and the Director of the Medical Industry Leadership Institute at the University of Minnesota. Dr. Parente has been the principal investigator for funded studies on consumer directed health plans since 2002, and advised Senator John McCain on health policy during the 2008 presidential campaign.

For most of his career, Dr. Stephen Parente has relied on databases created and curated by AHRQ to generate new knowledge and inform health policymaking, namely, the Medical Expenditure Examination Survey (MEPS) and the Healthcare Cost and Utilization Project (HCUP). These are one-of-a-kind data assets that we need to generate serious health policy research that no one other than the federal government has stepped in to fill,” said Dr. Parente.

For example, Dr. Parente received an investigator-initiated research grant from AHRQ to test whether health information technology (HIT) systems protect patient safety, improve health outcomes, and enhance efficiency. Dr. Parente used an algorithm developed by AHRQ and HCUP indicators on hospital discharge data, retrofitted to Medicare claims, to measure patient safety in every hospital in the United States over the course of 10 years. He overlaid these metrics with hospitals’ HIT investments to see if HIT systems were indeed successful at reducing medical errors and improving safety. The results were surprising:

In 2009, we found that there wasn’t much indication that HIT systems demonstrably improve safety and improve outcomes. When we looked deeper, looking at different order entry systems, there was nothing we could find to justify the investment. More recently we’ve measured the clinical complexity of the case, or the number of specialties involved. We found that if it’s an “easy” case you don’t get much efficiency from HIT at all. But if you have multiple specialties involved in a case, HIT can save your life. There’s only so much an internist can manage when the case is complex, and the HIT helps buttress the care. Without AHRQ money, without the AHRQ algorithm, and without AHRQ databases none of this would be possible.

Dr. Parente has more studies underway about ACA enrollment and what it means for Medicaid expansion, all using MEPS. “I can’t imagine how much more policy relevant you could be,” he said. “It’s all MEPS. Without MEPS, we have no shot.”

More recently, Dr. Parente used MEPS for a study on the Supreme Court’s ruling on the Affordable Care Act (ACA) and Medicaid expansion. “We found that the Supreme Court decision made things worse in most states,” said Dr. Parente. “When states sit out of Medicaid expansion it is better for the federal government because it reduces the amount of federal dollars expended. From a state perspective, it hurts their financial positions in the longer run.”

Dr. Parente has more studies underway about ACA enrollment and Medicaid expansion, all using MEPS. “I can’t imagine how much more policy relevant you could be,” he said. “It’s all MEPS. Without MEPS, we have no shot.”

With health care comprising such a considerable and increasing share of the American economy, Dr. Parente sees a continued need for federal investment in health services research and health datasets at AHRQ.

“The U.S. government funds war colleges to maintain a strong defense. Funding health services research is the same argument. It is an investment in the economic security of health.”
AHRQ Research Network Facilitates Delivery System Improvements
Featuring: Dr. Brent James and Dr. Lucy Savitz, Intermountain Healthcare, Salt Lake City, Utah

Brent C. James, MD, MStat, is the Chief Quality Officer and Executive Director of the Institute for Health Care Delivery Research at Intermountain Healthcare. He is known internationally for his work in clinical quality improvement, patient safety, and the infrastructure that underlies successful improvement efforts, such as culture change, data systems, payment methods, and management roles.

Lucy A. Savitz, PhD, MBA, is Director of Research and Education in the Institute. With more than two decades of health services research experience and having led 17 AHRQ-funded contracts, she currently directs the AHRQ ACTION II master contract.

Intermountain Healthcare is a nationally recognized, nonprofit system of 22 hospitals, a medical group with more than 185 ambulatory clinics, and an affiliated health insurance company. Intermountain provides a full range of services across the care continuum to patients and plan members in Utah and southern Idaho. “Providing excellent care of the highest quality at an affordable cost” is the heart of the system’s mission. It is through that mission that Dr. Brent James, Dr. Lucy Savitz, and their team of embedded health services researchers are striving to continuously improve their system’s performance and patients’ experience.

According to Dr. James, Intermountain is uniquely positioned to achieve mission critical performance excellence through the generation and deployment of evidence-based care process models via its Clinical Program infrastructure. “The biggest problem we have in health care is the perversity in the reimbursement system. If I keep people out of the hospital, I lose money…We have the luxury as a fully integrated delivery system with a large market share in our state to make the decision to do the best thing for a patient even though it hurts our bottom line.”

AHRQ has played a central role in these efforts, where Dr. James and his team have found opportunities for health care savings if providers are consistent in care delivery. For example, in a study on cystic fibrosis quality improvement and management, Dr. James and Dr. Savitz found that consistent execution of health care models could double life expectancy in their patients.

It is through AHRQ’s Integrated Delivery System Research Network (IDSRN) that cutting-edge results like these were discovered and rapidly shared within and across systems. The IDSRN and more recently ACTION II have capitalized on the research capacity of and research opportunities occurring within delivery systems. The AHRQ-sponsored master contract mechanism has supported Intermountain and other delivery systems to create and disseminate scientific evidence about what works in care delivery and research diffusion.

Funding for these rapid-cycle projects was historically small. “But with minimal investment, you got a lot of bang for your buck,” said Dr. James. For example, one IDSRN initiative was focused on assessing areas of health care waste. With nearly 50 percent documented overall waste, the project led to the development of a financial system for capturing frontline waste and highlighted opportunities to redeploy resources more efficiently.

In another AHRQ-funded grant, an Intermountain-based researcher, Dr. Flory Nkoy, developed a tool to prevent hospital readmissions of children with asthma, with mentoring from Drs. James and Savitz. The tool tracks peak flow, showing degradation before an attack and allowing physicians to intervene before the child needs to go to the hospital. Keeping children out of the hospital improves their health outcomes, and helps drive down health care costs. “We’ve found it’s highly effective, and we believe it will become even more useful when the tool is used in adults,” said Dr. Savitz. “This is the goal of AHRQ funding—to fund one project that leads to significant advances in other areas.”

Dr. James and Dr. Savitz agree that AHRQ funding for real-world, rigorous testing of health care innovations in the “three Ds”—delivery, design, and discovery—remains essential. As Dr. James explained:

“NIH generates new knowledge, but it is AHRQ’s job to find out how to best deploy it to physicians and patients. You can have all the knowledge in the world, but if you can’t use it, you can’t deploy it, it’s meaningless.”
Estimating Waste in the Healthcare System

The bar chart reflects the findings of a 2006 study conducted by Intermountain Healthcare on waste in the health care system. The study followed 61 caregivers and professionals in technical support roles. The chart shows the percentage of time in each activity type that the researchers found to be wasteful and then gives low, moderate, and high estimates for the overall percentage of time wasted. While the chart shows that the moderate percentage of waste is 35 percent, those who conducted the study believe this to be a conservative estimate, with actual waste being even higher.

Activity Categories and Definitions

<table>
<thead>
<tr>
<th>Activity class*</th>
<th>Definition/description/examples</th>
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</thead>
<tbody>
<tr>
<td>1. Operations</td>
<td>Bedside caregivers: time spent with patients or family performing direct care. Non-bedside staff: job-specific activity (e.g. phlebotomist drawing blood, scrub tech assisting surgeon).</td>
</tr>
<tr>
<td>2. Clarifying</td>
<td>Communication of information about work processes, including meetings, reports, rounds, teaching, ‘huddles’, perusing medical records, locating information, paging or telephoning.</td>
</tr>
<tr>
<td>3. Error/Defect</td>
<td>Mistakes or interruptions in work that require a corrective response. Errors included planning failures, wrong actions or plans, and medication errors. Defects involved equipment- (including computers) or supply-related problems.</td>
</tr>
<tr>
<td>4. Processing</td>
<td>Redundant work or activities that do not fundamentally change service delivery, including documentation, paperwork and preparation time.</td>
</tr>
<tr>
<td>5. Motion</td>
<td>Inventory/stocking supplies, travelling, waiting, and locating missing items or people.</td>
</tr>
<tr>
<td>6. Other</td>
<td>All other activities not categorized above (e.g. talking to the observer).</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Unanticipated external (to the worker) requests from people or other events that divert attention from work.</td>
</tr>
<tr>
<td>Location Changes</td>
<td>Movement from one work area to another requiring more than 10 steps.</td>
</tr>
</tbody>
</table>

*Activity categories included: operations, clarifying, error/defect, documenting, paperwork, preparation time, inventory/stocking, travelling, waiting, locating and other

Getting Care Right for Millions of Americans at UnitedHealth Group

Featuring: Dr. Reed Tuckson, Tuckson Health Connections, Edina, Minnesota

Reed Tuckson, MD, FACP, is a physician first, focusing on the myriad health issues patients face every day. Over the course of more than 35 years, he has engaged in nearly every sector of health care, serving as the Commissioner of Public Health for the District of Columbia; the Senior Vice President for Programs of the March of Dimes Foundation; the President of the Charles R. Drew University of Medicine and Science; the Senior Vice President for Professional Standards of the American Medical Association; the Executive Vice President and Chief of Medical Affairs for UnitedHealth Group; and now as the Managing Partner of Tuckson Health Connections.

For 13 years, Dr. Reed Tuckson served as Executive Vice President (EVP) and Chief of Medical Affairs for UnitedHealth Group, a Fortune 20 health and wellbeing company that enjoys relationships with 740,000 health care professionals, 80,000 dentists, 5,600 hospitals, and 70 million Americans. In his capacity as the senior physician for America’s largest health company, he used health services research to make UnitedHealth Group an industry leader in care improvement. As Dr. Tuckson explained:

“In today’s health care environment there are two dominant concerns. First, improving quality and second, addressing rapidly escalating costs. Those two factors, in addition to the increasing prevalence of preventable chronic illness, create an inescapable mandate for practical and actionable evidence-based information to support how health and medical services are organized, financed, and refined…This is the most important era in the history of health services research—to make contributions that are essential to not only the nation’s health, but also the nation’s and individual’s fiscal health.

AHRQ plays a central role in this mandate for better care, at better value. “AHRQ is the essential government agency to advance the health services research capacity of the nation,” said Dr. Tuckson. “We need the products and the intellectual processes of AHRQ today more than ever.”

AHRQ’s leadership in advancing methodologies for sound research design, the agency’s landmark work shining a bright light on health disparities, and their work to respect and advance the experiences of individual patients in care delivery are priorities that, as Dr. Tuckson explains, “may not be intuitively obvious to the casual observer.” However, for Dr. Tuckson they exemplify “AHRQ’s leadership in providing the evidentiary basis necessary to address underappreciated but important problems that are grounded in a concern for health of all Americans, regardless of socioeconomic or ethnic or political status.”

One specific product Dr. Tuckson found “extremely important” to UnitedHealth Group is AHRQ’s Guide to Clinical Preventive Services. The guide summarizes evidence-based recommendations on screening, counseling, and preventive medication developed by the U.S. Preventive Services Task Force—an independent, nongovernmental panel of primary care providers. The guide informs health care practitioners’ and other stakeholders about existing evidence on what works, and is a critical resource for health plans such as UnitedHealth Group. As Dr. Tuckson explained:

“One of the unfortunate realities of science is that answers are not often black or white, but are made up of nuances and subtleties…The Guide provides a legitimate, trustworthy, and thoughtful scientific forum to evaluate evidence so that others can use it to make fundamental decisions that affect the health of millions of people. It is a great example of the practical importance of AHRQ, and why it’s so important the agency have the resources necessary to get it right, and to expand the capacity to produce an even broader array of science-based products that are of service to the nation.”

Dr. Tuckson sees AHRQ as “mission critical” in a rapidly evolving era of health care complexity.

New discoveries, new technologies, and new cost concerns are propelling us forward, and we urgently need more robust evidence about what works and how to use innovations intelligently and responsibly. AHRQ helps the delivery system get health care right, and for the patient to know when they’ve received it. This is fundamentally in the public’s interest.”
Improving Heart Health and Disparities with Evidence

Featuring: Dr. Eduardo Sanchez, American Heart Association, Dallas, Texas

Eduardo Sanchez, MD, currently serves as Deputy Chief Medical Officer at the American Heart Association (AHA) where he is working to protect the heart health of 300 million Americans. Prior to joining AHA, Dr. Sanchez was the Vice President and Chief Medical Officer for Blue Cross Blue Shield of Texas, Commissioner of the Texas Department of Health (2001 to 2004), and Commissioner of the Texas Department of State Health Services (2004 to 2006).

Heart disease remains one of our nation’s costliest public health threats, both in its human and financial toll. About 600,000 Americans die of heart disease every year—that’s one in every four deaths—and it’s the leading cause of death for both men and women. It costs the United States $108.9 billion each year for health care services, medications, and lost productivity. And yet, the costs associated with heart disease are generally preventable.

Dr. Eduardo Sanchez has fought this debilitating chronic disease throughout his public health career and especially during his time in Texas, where three out of every 10 Texans die of cardiovascular disease and stroke each year, and where the associated hospitalization charges cost $20 billion in 2010 alone. As the evidence has shown, minority populations disproportionately experience higher rates of heart disease and stroke and have poorer access to quality care, making the need to address disparities a critical step toward reducing the impact of heart disease.

AHRQ’s National Healthcare Disparities Report—an annual publication mandated by Congress that highlights which populations experience lower quality of care, lower access to care, and whether or not differences between populations are improving—has been particularly influential in his efforts to improve public health. “As a [state health officer], eliminating disparities was always a priority,” said Dr. Sanchez. “It was my priority at Blue Cross Blue Shield, and at American Heart Association this is part and parcel to our mission.”

The National Healthcare Disparities Report has helped Dr. Sanchez understand how disparities manifest in Texas and, more importantly, understand how the shifting demographics made understanding disparities ever more important:

In Texas, it is about understanding how disparities manifest in our state. In a state where already less than 50 percent of our population is white, and the population group of ‘other’ races and ethnicities is growing, the relevance of health care disparities looms large.

At Blue Cross Blue Shield of Texas, Dr. Sanchez used the report’s evidence on disparities to validate the problem and encourage the health care insurance provider to better target coverage options and prevention initiatives to populations in need.

We could use the report to target our services by zip code or population, or think about how we might influence what is happening in the health care environment itself. It shed a light on the problem, influenced our commitment to eliminating disparities, and helped us make that happen.

Now, as the American Heart Association’s Chief Medical Officer, Dr. Sanchez uses this evidence to encourage partners and stakeholders to address health care disparities more strategically and collaboratively.

Going forward, Dr. Sanchez sees a critical role for AHRQ as an honest broker of evidence and convener about what works in addressing disparities.

We need [AHRQ] to help frame the research agenda around health services research and public health services research, play a role in dissemination of findings, play a role in tracking quality and improvements in quality as a result of our taking stock and making change, and in tracking disparities and progress we’re making to eliminate those disparities.
Hospitalization for Congestive Heart Failure

Some hospitalizations for heart failure are unavoidable, but rates of hospitalization can be influenced by the quality of outpatient care. The chart below shows hospital admissions for congestive heart failure by race and ethnicity. The hospitalization rates for African Americans are much higher than those of other races and ethnicities.

Karen A. Scott, MD, MPH, is the Vice President for Quality and Patient Safety at the New York Presbyterian Hospital. She leads the Quality Innovation and Improvement Department of the hospital’s Quality Division and is responsible for developing and leading improvement initiatives in clinical quality, efficiency, and patient safety work across the five hospital campuses of the Columbia and Cornell Medical Schools. Dr. Scott has experience in leading work on patient safety culture, improvement initiatives in hospital and outpatient settings, including medication safety, communication, and efficiency, and reducing readmissions.

Dr. Karen A. Scott is on a quest to protect the health and safety of all patients—making sure that patients don’t leave the hospital sicker than when they came in, and trying to prevent them from being readmitted. In so doing, she uses several evidence-based resources created and funded by AHRQ. “I’ve been watching and interacting with AHRQ over the last 15 years and their role as a leader and national convener of expertise in health care delivery, quality, safety continues,” said Dr. Scott. “AHRQ is a place we look for resources. There’s no other central place in this country to get that information.”

Most recently, Dr. Scott is using the Team Strategies and Tools to Enhance Performance and Patient Safety or “TeamSTEPPS.” TeamSTEPPS is the result of the collaboration of AHRQ and the Department of Defense during a three year research and development project. During the creation of the tool, AHRQ and the Pentagon convened a meeting of 30 professionals to contribute their expertise on teamwork in the health care system. The multimedia toolkit produced by this collaboration helps hospitals implement team strategies among health care professionals to improve efficiency and safety. Dr. Scott is actively using the tools from TeamSTEPPS to do a better job of incorporating regular discussion about near misses and safety events into the hospital’s discussions with front line staff.

Dr. Scott also praises the utility of AHRQ’s other national resources, including toolkits and datasets. According to her, AHRQ “levels the playing field” for all hospitals, providing her and others with unbiased, trustworthy data and evidence necessary to evaluate hospital performance. As she explained:

“I don’t think a single hospital would have the resources to do this all themselves; to put together all the pieces... It’s hard to imagine that very many hospitals or systems would have the ability to put resources into this work and to convene the level of expertise required to produce the same level of products. AHRQ also has the ability to make the tools available to everyone. That’s the value of having a neutral convener like AHRQ.

Going forward, Dr. Scott would like to see greater federal investment in studying ways to help hospitals integrate quality strategies during a time when hospital revenue is on the decline. AHRQ would be the logical home for that work.

We want our patients to have the best care. But hospitals and health systems struggle with putting all the pieces of the quality chasm together—quality measures, [patient satisfaction], readmissions. And doing all this more efficiently. These are day-to-day realities for a frontline nurse or medical director trying to respond to all these initiatives, and take care of individual patients. How do health care delivery systems and hospitals best integrate all these aspects of quality? AHRQ is well positioned to help us integrate all of these quality initiatives into the care we provide.
Karen Minyard, PhD, has directed the Georgia Health Policy Center (GHPC) at Georgia State University’s Andrew Young School of Policy Studies since 2001. Minyard connects the research, policy, and programmatic work of the center across issue areas, including community and public health, long-term care, child health, health philanthropy, public and private health coverage, and the uninsured.

Sharon Cooper, MSN, MA, was first elected to the House of Representatives in 1996. In 2004, she was elected Majority Caucus Chairman by her Republican colleagues, making her the highest ranking woman in the Georgia House—the highest rank ever attained by a woman. Representative Cooper chairs the Health and Human Services Committee, one of the busiest committees in the House. She is also a member of the Rules, Judiciary Non-Civil, and Regulated Industries Committees.

Twenty years ago, Georgia business leaders, health care providers, philanthropic donors, and state policymakers shared concerns that the state legislature—in session only 40 days each year—did not allow lawmakers sufficient time to research and address complex health policy issues. With the shared goal of excellence in health policymaking, these groups formed the Georgia Health Policy Center (GHPC) in 1995. Housed within Georgia State University’s Andrew Young School of Policy Studies, GHPC provides objective, evidence-based research to policymakers that helps them make informed decisions about health policy and programs in their state.

Dr. Karen Minyard leads the work of the Center and one of its most innovative and popular programs, the Legislative Health Policy Certificate Program. Over the past 7 years, this program has developed a cadre of legislators with a more in-depth knowledge and understanding of health policy issues—from health care financing to childhood obesity to rural and urban health system design.

Key components of the program are computer simulation models, stock and flow maps, and behavior over time graphs. Built upon available data and evidence by Dr. Minyard and her team, these systems thinking tools are used by legislators to provide real time, hands-on experience in seeing how their health policy decisions impact health outcomes over time.

“Our maps and models tell lawmakers if you do this, this will likely happen based on the available evidence,” said Dr. Minyard. “The models go beyond a piece of literature or a journal article. They help create a dynamic way to integrate all research on a particular issue and translate it to lawmakers.”

According to Dr. Minyard, AHRQ’s research and datasets are essential in building the models and helping policymakers understand the impact of their policy decisions. “We definitely look to AHRQ-funded research, datasets, and toolkits, and we’ve received AHRQ funding ourselves to generate new evidence,” said Dr. Minyard. “We couldn’t build the models if we didn’t have evidence generated by AHRQ.”

Georgia State Representative Sharon Cooper is a champion of the program and the use of evidence in policymaking. “As a nurse, and one of only a handful of health professionals in the House of Representatives, I know how important good, quality information is to our decision-making.”

Rep. Cooper serves as the Chairwoman of the House Health and Human Services Committee, where she strongly encourages participation in the GHPC’s legislative certificate program among members. “The complexity of health policy in our state and nation requires us to be able to quickly analyze numerous pieces of legislation and contemplate the unintended consequences of those policy decisions,” said Rep. Cooper. “I have no doubt that our committee is more prepared to analyze and discuss legislation as a result of this program.”

Dr. Minyard believes it is important to support AHRQ and health services research that allows her team to create evidence-based, credible, policy decision tools. “For us to provide legislators and other stakeholders with evidence about policy, we have to have the research to back it up,” she said. “We’re always looking for more research to support our activities.” She also sees an important role for AHRQ in creating a health system where businesses and communities can thrive, health care costs are minimal, and people are healthy.
Using Maps to Understand and Prevent Chronic Disease

Stock and flow maps are tools that can depict a system in a common visual language and allow people to see how things are connected, where the boundaries of the system are, and how feedback loops contribute to the complex dynamics that occur in real-life situations. The map created by the Georgia Health Policy Center based on available evidence was used by policymakers, and later refined, to facilitate conversation about disease prevention. Looking from left to right at the map below, one can see how people may move from being safe and healthy, to being at risk for disease and then developing a chronic disease. Policymakers had to think about what policies and programs could slow down the rate that people “flow” out of the healthy category or what could be done to reduce the “flow” of at-risk individuals developing chronic disease. As people live longer with chronic diseases, the afflicted and chronic population grows. With that growth comes demand for services and increased spending on this population. In this map, policymakers learned about the reinforcing loop or “vicious cycle” that can monopolize all health care spending in this system. They increase their understanding that, by prioritizing prevention strategies, they may keep more people healthy and reduce costly spending on chronic disease.

The process of creating the map helped policymakers better understand the system in which this complex problem “lives,” identify the levers for prioritizing strategies and making change, and neutralize conflict or bias. Perhaps more importantly, its impact lasted well beyond the session by transforming how they framed this issue in subsequent policy meetings and dialogue.
Improving Medicaid Performance through Collaboration

Featuring: Dr. Judy Zerzan, Colorado Department of Health Care Policy and Financing, Denver, Colorado

Judy Zerzan, MD, MPH, is the Chief Medical Officer and Deputy Medicaid Director at the Colorado Department of Health Care Policy and Financing. As Chief Medical Officer, she provides clinical guidance for policy, quality improvement, and program development for medical and pharmacy benefits.

With a cost of more than $430 billion in fiscal year 2012, Medicaid represents one of the largest benefit programs, providing essential health care assistance for more than 55 million of the nation’s most vulnerable Americans—low-income seniors, children, and persons with disabilities. Since the program’s inception, the cost of Medicaid has increased at a faster pace than the U.S. economy. Medicaid expenditures are projected to increase at an average rate of 6.4 percent and reach $795 billion by 2021 when enrollment is expected to reach nearly 78 million Americans.

Getting the most bang for the Medicaid buck is thus essential for both federal and state fiscal health, and AHRQ has played a critical role in developing and disseminating evidence to help Medicaid’s state-based stewards make better decisions for their beneficiaries. As Colorado’s Chief Medical Officer, Dr. Judy Zerzan is responsible for determining how to best treat the state’s more than 750,000 Medicaid beneficiaries with the limited resources available.

Colorado’s Medicaid program cost more than $4 billion in 2012, so Dr. Zerzan must make every dollar count.

To inform her decision-making, Dr. Zerzan has participated in the Medicaid Medical Directors Learning Network (MMDLN), founded in 2005. Initially funded by AHRQ, the MMDLN provides a forum for state Medicaid leaders to share evidence about what is and is not working in their states and to collaboratively develop the best care systems for Medicaid beneficiaries. “Our unofficial motto is share senselessly, steal shamelessly,” said Dr. Zerzan. “We don’t need to reinvent the wheel and go it alone. We are all struggling with the same issues. The MMDLN has been very helpful as we learn from our peers about what they’ve tried and what’s worked.”

To date, MMDLN has worked collaboratively to address such issues as atypical anti-psychotics, opiate abuse, re-hospitalization rates, and perinatal outcomes using state data. The network also uses evidence generated in AHRQ’s Effective Health Care program, and from AHRQ’s Healthcare Utilization Project (HCUP). Dr. Zerzan recalls the network’s focus on re-hospitalizations as “the best example of shared learning” and the most influential to her work. Collaborating with the other states in the network gave her a benchmark as to where Colorado stood on re-hospitalization rates and demonstrated that simple nonpayment for readmissions was not enough to improve hospital care in many states. Before reviewing what others states in the MMDLN had done, Colorado and stakeholders were struggling to design a re-hospitalization metric because it was “too hard” and a good benchmark wasn’t available. After sharing the experiences and data from MMDLN, Dr. Zerzan was able to convince Colorado to implement a quality incentives program for hospitals to encourage better care in hospitals, limiting readmissions and the costs associated with them.

MMDLN is no longer funded by AHRQ and is now provided in-kind support by the National Association of Medicaid Directors. Nevertheless, Dr. Zerzan sees a continued role for AHRQ and health services research in improving Medicaid efficiency and beneficiary experiences:

We are working to keep Coloradans healthy. But somebody’s got to improve the health of the population as a whole. America spends a lot on Medicare and Medicaid, and it’s the government’s responsibility to see how to best spend those dollars and get the most value. States don’t have the capacity, and the private sector is often looking within their own systems, not across all systems. AHRQ provides the broader view that is so important. AHRQ tells us how we can make our health system work better and make our clients healthier.
David Penson, MD, MPH, is a board-certified urologist who focuses on urological malignancies, particularly bladder and prostate cancer. He is an internationally recognized expert in the care of both of these common cancers and is also a federally-funded researcher with a focus on patient-reported outcomes, survivorship, and comparative effectiveness in prostate cancer. He serves as the American Urological Association National Chair for Healthcare Policy and previously served as the organization’s representative to the Commission on Cancer.

The bug to improve care delivery bit Dr. David Penson while he was in his residency. “I had wanted to do research. Most people were focused on discovery in the lab, but I thought it was more fulfilling to find ways to make systems work better.” Dr. Penson applied, and was accepted into the Robert Wood Johnson Foundation Clinical Scholars Program at Yale University, a prestigious training program for health leaders who seek to improve health and the quality of health care.

Today, Dr. Penson’s research focuses on how to “maximize outcomes using the treatments we have” and get information about what works to patients and providers so they make better decisions. “If we better use the resources we have, we can better improve health,” said Dr. Penson.

His work serves him well at the Vanderbilt University Medical Center, where he sees patients with urological cancer two days a week and directs the Center for Surgical Quality and Outcomes Research. There is no shortage of opportunities to better understand what works, for what patients, and in what settings. As Dr. Penson further explained:

Choosing therapy in prostate cancer is about as tough as it gets. It’s unlike other cancers where you have few treatment choices. There are a lot of gray areas in prostate cancer treatment, and many opportunities to better understand what makes a good surgery or a good radiation treatment and how to help patients decide what’s best for them.

With funding from AHRQ, Dr. Penson assessed the effectiveness of treatments for prostate cancer to better understand patients’ preferences. He studied 3,600 men choosing between radiation and surgery. “It’s not super sexy—we didn’t find the cure for cancer—but we’re making just as big an impact. Maybe bigger,” he said.

For example, he sees bringing his health services research to the frontiers of personalized health decision-making in prostate treatment:

…Where a man in Wichita newly diagnosed with prostate cancer can go to a website, type in his demographic data, type of cancer, social support network, etc. and then he sees a page that says, ‘Looking at men just like you, here are, on average, what your outcomes are likely to be with surgery, radiation, or active surveillance. If you choose surgery, you want this type of provider. Radiation, that type, etc.’ This is useful information a man can use to make his treatment decisions.

Without AHRQ, Dr. Penson sees a health care system in which “safety innovations disappear” and physicians—including specialty societies developing practice guidelines based in part on evidence from AHRQ—would lack information needed for continuous quality improvement.

Providers, for the most part, have their heart in right place. They want to do right thing. But if you see patients five days a week, it is so hard to keep up with literature. AHRQ helps providers understand the latest treatments, and what’s most effective…

“AHRQ is the arbitrator of objective information for providers to stay up to date. No one else does this like AHRQ...If they didn’t take the lead, these efforts would die.”
Risa Lavizzo-Mourey, MD, MBA, has served as President and CEO of the Robert Wood Johnson Foundation for more than 10 years. Under her leadership, the Foundation has researched, evaluated, and implemented transformative programs tackling the nation’s most pressing health issues, with the goal of creating a national culture of health. Dr. Lavizzo-Mourey is a member of the Institute of Medicine of the National Academy of Sciences; the President’s Council for Fitness, Sports and Nutrition; and several boards of directors.

At the helm of the Robert Wood Johnson Foundation (RWJF)—the nation’s largest health philanthropy—Dr. Risa Lavizzo-Mourey combines the scientific and ethical values she learned as a doctor with an enduring conviction that meaningful philanthropy must achieve lasting social change. In this regard, she is well-suited to lead the Foundation’s efforts to improve both the health of everyone in America and their health care—how it’s delivered, how it’s paid for, and how well it does for patients and their families.

To fulfill its mission, the Foundation relies on research supported by AHRQ. According to Dr. Lavizzo-Mourey, over the last 15 years, AHRQ has supported the sorts of data collection and applied research that have greatly increased the Foundation’s understanding of how our health care system works. “Information is power, and AHRQ has generated the type of evidence that has put the country’s decision makers in a position to improve the lives of all Americans,” she said.

Aligning Forces for Quality (AF4Q) is one such RWJF initiative that is closely aligned with AHRQ’s mission. AF4Q asks the people who get care, give care, and pay for care to work together toward common, fundamental objectives to lead to better care. The 16 geographically, demographically, and economically diverse communities participating in AF4Q together cover 37 million people, or 12.5 percent of the U.S. population (see map).

AF4Q’s hard work to achieve the signature program’s goals has been fostered by AHRQ’s Learning Network for Chartered Value Exchanges or CVEs, which brings together 24 community collaboratives, including 14 of the 16 AF4Q communities, to share ideas and listen to experts discuss best practices for building healthier communities.

Dr. Lavizzo-Mourey reflects on the AHRQ resources that advance AF4Q’s efforts:

Improving the health of a community takes a lot of hard work and perseverance, but without the right resources to draw on, no collaborative effort will go very far. After all, improving the health and health care of a community is dependent on many smaller efforts to better one facet of that bigger picture. And managing these varied but equally important priorities can be a difficult lift for a community just getting started on the road to improved quality. Toward that end, AHRQ has long provided AF4Q communities and other multistakeholder collaboratives with resources that share key lessons learned for effectively building and sustaining their efforts.

By working together, AHRQ and RWJF have helped each other—and the AF4Q community collaboratives they both support—achieve their shared vision for improving U.S. health care one community at a time.

Through her work at RWJF, Dr. Lavizzo-Mourey sees a critical need for the federal government to invest in health services research so that health care may be more accessible and affordable. “This field of study helps connect research with the users of research who can influence policy and practice on a local and national scale,” she said. “Government support of health services research is necessary to address collective, societal health issues such as rising health care costs, access to high-quality and affordable health care, and disparities in care.”

Dr. Lavizzo-Mourey is proud to be able to support health services research, and sees great value in RWJF’s partnership with AHRQ. It is through this partnership that each may produce the evidence and foster the culture necessary to advance health care.
Focusing on the Health System’s End User – the Patient

Featuring: Myrl Weinberg, Chief Executive Officer, National Health Council, Washington, DC

Myrl Weinberg, MA, FASAE, CAE, is chief executive officer of the National Health Council, the only organization that provides a united voice for the more than 133 million people living with chronic diseases and disabilities, and their family caregivers.

In her role as CEO of the National Health Council (NHC), Myrl Weinberg advocates on behalf of millions of American patients with chronic diseases and disabilities. One of her organization’s primary goals is to empower patients by educating them about their health care and the importance of being actively involved in their health care decisions. For her, federal funding for health services research is crucial for advancing the delivery of patient care:

“I cannot overstate the fact that federal support of medical and health services research is vital to people living with chronic conditions. This is because federal research moves us closer to making the impossible possible – saving expenses through effective new treatments and more efficient delivery of care, and saving lives in the process.”

The NHC has collaborated with AHRQ for many years to ensure the patient voice is heard by the health care delivery system. “The most effective way to improve the delivery of quality health care in this country is to better incorporate the patient perspective,” says Ms. Weinberg.

In particular, NHC has been involved with AHRQ’s campaign to encourage people with chronic conditions to take control of their health by asking questions, better understanding their rights as patients, and learning to work with their team of providers to find the right treatment plan for their personal health needs. According to Ms. Weinberg, AHRQ’s patient-engagement activities not only have the potential to improve a patient’s care, health outcomes, and experiences in the health care system, but also to reduce health care costs.

“Federal research moves us closer to making the impossible possible – saving expenses through effective new treatments and more efficient delivery of care.”

Ms. Weinberg argues that it is essential for the federal government to invest not only in medical research, but to “complete the health care picture” by investing in health services research. As she described, “without an efficient health care delivery system with knowledgeable and engaged patients, the health care puzzle will be incomplete.” She sees AHRQ as the agency that can break down silos to bring all stakeholders together to make our health care delivery system more safe, secure, and efficient.

Ms. Weinberg has already seen AHRQ’s success at breaking down these silos in the area of comparative effectiveness research. With so many treatments to address chronic disease, it is often difficult for patients and physicians to decide on the best way to proceed with treatment and care. AHRQ’s work informs these decisions.

Looking ahead, Ms. Weinberg sees AHRQ’s commitment to incorporating the perspective of people with chronic conditions as a model for other federal agencies doing health research.

“Federal research moves us closer to making the impossible possible – saving expenses through effective new treatments and more efficient delivery of care.”
The Next 15 Years

During the last 15 years AHRQ has accomplished much, but there’s much more to do. The health care system faces many challenges in this transformative era—significant coverage expansions, sweeping demographic shifts, increasing prevalence of costly chronic diseases, rapid advances in technology, and rising health care costs—that raise important questions about how our nation will respond:

- How can we assure patients will not leave the system sicker than when they entered?
- How can we best harness the power of technology to engineer better systems and deliver on the promises of increased safety and efficiency?
- How do we achieve the best care at lower cost?
- How do we best connect individuals with the care they need, when they need it, and on their terms?
- How do we best disseminate evidence to ensure it is readily available to health care providers and patients and integral to their choices and preferences?

The challenges posed by the changing landscape are undoubtedly complex, but they are not insurmountable. Over the next 15 years and beyond, AHRQ will continue to play an essential role in generating the evidence to help patients, health care providers, and other decision makers in the public and private sectors navigate these uncharted waters. To be sure, science alone will not change our health care system and make care better. Even with the best evidence, political will and public understanding are required to make necessary and sometimes painful changes. Nevertheless, health services research can ensure that the most critical decisions—from choosing ways to reap the benefits of care coordination, to choosing ways to restructure federal entitlements—are not made in the dark.

“AHRQ can make sure that we have really good information so that as we build for that future, we’re building on solid information. In the long run, having this evidence will actually allow us to go further, farther, faster.”

– Dr. Karen Minyard, Georgia Health Policy Center, Atlanta, Georgia
Endnotes

17. AHRQ’s Multiple Chronic Conditions Research Network, Downloaded Novem- ber 22, 2013. Available at: http://www.ahrq.gov/legacy/research/mccrn.htm
19. The Medical Expenditure Panel Survey or MEPS is a set of large-scale surveys of families and individuals, their medical providers (doctors, hospitals, phar- macies, etc.), and employers across the United States. MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers.
20. The Healthcare Cost and Utilization Project or HCUP is a family of databases and related software tools and products developed through a Federal-State-In- dustry partnership and sponsored by AHRQ. HCUP enables research on a broad range of health policy issues, including cost and quality of health ser- vices, medical practice patterns, access to health care programs, and outcomes of treatments at the national, state, and local market levels.
23. “Texas Plan to Reduce Cardiovascular Disease and Stroke,” Texas Department of State Health Services. Available at: http://www.dshs.state.tx.us/wellness/
25. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) provides a standardized survey instrument and data collection methodology for measuring patients’ perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting patients’ perspectives of care information that would enable valid comparisons to be made across all hospitals. In order to make “apples to apples” compar- isons to support consumer choice, it was necessary to introduce a standard measurement approach: the HCAHPS survey, which is also known as the CAHPS’ Hospital Survey; or Hospital CAHPS. HCAHPS is a core set of ques- tions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data hospitals currently collect to support improvements in internal customer services and quality related activities.
27. Ibid.
29. Ibid.
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