AHRQ Update

AHRQs National Healthcare Quality and Disparities Reports: Resources for Health Services Researchers

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Some would say that the beginning of wisdom in health services research is the realization that what cannot be measured cannot be changed. Until recently, we lacked a single, accessible source of national longitudinal data on health care quality and disparities related to race, ethnicity, and socioeconomic status. Along with the rest of the health services research community, we at the Agency for Healthcare Research and Quality (AHRQ) knew all too well the frustrations and limitations on research caused by the lack of such data.

Since the release of AHRQs first *National Healthcare Quality Report* (NHQR) and *National Healthcare Disparities Report* (NHDR) in December 2003, AHRQ has been working to resolve this dilemma. I have discussed these reports in previous commentaries in this journal, and I am proud to report that with the 2005 annual reports, which we released in January 2006, we now have at least 3 years of trend data on measures of both overall quality and specific disparities, such as those related to race, ethnicity, and socioeconomic status.

With the publication of the most recent reports, we have the data for some much needed research. I would like to note that reports are the result of collaboration among agencies across the Department of Health and Human Services. These reports would not be successful without the contributions made by senior scientists across the Department, especially from the National Center for Health Statistics.

The NHQR and the NHDR are the only reports that track the nation's progress each year in improving health care quality and reducing health care disparities across a broad range of conditions, services, and population groups. They identify nationwide strengths and opportunities for improvement in health care, highlight successes, and suggest where interventions are most needed and would yield the greatest results. While the reports make clear that

excellence in health care is being achieved for many, they also reveal significant gaps in health care quality and access, especially for racial and ethnic minorities and the poor.

Both reports were restructured in 2004 as chartbooks, making them more accessible and useful for health policymakers and the general public. Detailed supporting data are available in appendix tables available on AHRQ's website. In the 2005 reports, the presentation of information is further refined and standardized. They also include new composite measures that offer a broader perspective on quality and access; these measures include heart attack, heart failure, pneumonia, and patient-provider communication problems. Furthermore, new sources of data have been tapped to expand the reports; these include information on substance abuse, cancer, and hospital care for the conditions with new composite measures.

In this commentary, first, I'd like to discuss the contents of the two reports. I think you will agree that the reports offer a wealth of useful data. After that, I'd like to briefly comment on some possible issues the reports raise for exploration by health services researchers. Each report focuses our attention as health services researchers on important unanswered questions.

THE NATIONAL HEALTHCARE QUALITY REPORT

The NHQR presents the broadest examination ever undertaken of the quality of health care in the U.S. The breadth of this assessment is unparalleled. The data offered in table appendices should be especially useful to researchers. AHRQ's goal of providing information about race and ethnicity stratified by age, gender, income, education, insurance, urban/rural location, and disability status on as many measures as possible gives researchers significantly greater detail than other sources.

Quality is improving for most measures, but the overall pace of change is slow and variable. Improvements have been demonstrated, such as those in patient safety and in care for certain diseases and populations. However, for too many measures we will not attain optimal care for many years if the current rate of change is maintained. For a few measures, the evidence of sustained improvement demonstrates that dramatic change is possible and presumably replicable.

The Quality Report has four basic themes:

1. *Health care quality continues to improve at a modest pace across most quality measures:* The median rate of annual change for the 44 core measures is a 2.8 percent improvement—the same rate of improvement as reported in the 2004 NHQR. Of 44 core categories, slightly over half (23 or 52 percent) improved. Nineteen (43 percent) were unchanged. Only two (4.5 percent) became worse.¹
2. *Health care quality improvement is variable, with noteworthy areas of high performance:* The four measures of patient safety improved by an overall median of 10.2 percent, with a range of 2–39 percent. The quality measures which showed the most improvement are those for diabetes, heart disease, respiratory conditions, nursing home care, and maternal and child health care. The overall rate of change for these measures was 5.4 percent. The quality measures which showed the least improvement are those for HIV and AIDS, cancer, end-stage renal disease, mental health and substance abuse, and home health care. The overall rate of change for these measures was 0.3 percent.
3. *Health care quality is improving, but more remains to be done to achieve optimal quality:* Many measures are showing significant improvement but we are still falling very short of optimal quality (e.g., breast cancer, end-stage renal disease, high blood pressure, and pneumonia). Many measures are slow to change and present significant challenges to quality improvement (e.g., late stage breast cancer, new HIV cases, smoking, overuse of antibiotics, heart attacks, and medication errors).
4. *Sustained rates of quality improvement are possible:* The following measures showed an average rate of annual improvement of at least 2.5 percent over 4 or more years:
 - Adolescents age 13–15 years who received 3 or more doses of hepatitis vaccine (13.5 percent average annual improvement)
 - Children age 19–35 months who received all recommended vaccines (5.5 percent)
 - Hospital admissions for pediatric gastroenteritis (4.2 percent)
 - Acute myocardial infarction (AMI) mortality rate (3.0 percent)
 - Hospital admissions for pediatric asthma (2.5 percent)

(Note that four of these five measures are for children and adolescents.)

The 2005 report shows that there has been much more rapid improvement in some measures, especially where there have been focused efforts to improve performance. For example, measures for heart attack, heart failure, and pneumonia showed an annual improvement of 9.2 percent. These are priority areas for Medicare, where participating hospitals have received special and focused help from Medicare's Quality Improvement Organizations.

Quality improvements for the whole nation will result from coordinated and focused actions at Federal, State, and local levels to extend the benefits of regional and local successes nationwide. Sustained improvement by six states² showed performance that was significantly above average for two or more years on at least three of the following core measures:

- mammography screening
- hemoglobin A1c (HbA1c) testing (average blood glucose)
- dialysis patients on a kidney transplantation waiting list
- early prenatal care
- pediatric asthma hospitalization rate.

THE NATIONAL HEALTHCARE DISPARITIES REPORT

The Disparities Report is inextricably linked to the Quality Report. Equity is a core element of quality care, and many communities appreciate that reducing disparities may be a highly effective and efficient means of improving overall population health. While we find improvements in quality and access on a wide front, it is inconsistent, and the need for action to improve quality of care for all Americans is as great as ever. In addition, what we're seeing is an enormous opportunity not only to close the gap in health care disparities, but also to improve the overall health of all populations. The issues—like the NHQR and NHDR—are closely related.

The NHDR tracks disparities in both quality of health care and access to health care. It represents the most comprehensive annual examination of disparities in health care ever undertaken in the United States. This report provides a wide-ranging national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general population and within priority populations and tracks the success of activities to reduce disparities.

The Disparities Report has four main themes:

1. *Disparities still exist.* Disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system.

For example, blacks received poorer quality of care than whites in 43 percent of the core measures, and American Indians and Alaska Natives received poorer quality of care than whites in 38 percent of measures.

2. *Some disparities are diminishing.* The good news is that health care disparities are narrowing for many minority Americans. For racial minorities, more disparities in care are becoming smaller than are becoming larger. The bad news is that the rate of change is often slow and that the majority of disparities for both quality and access are widening among Hispanics.
3. *Opportunities for improvement remain:* All groups studied faced some disparities in quality of care. Some disparities in quality were prominent for multiple groups (e.g., new AIDS cases, problems with timeliness of care, and problems with patient-provider communication). The report also indicated that disparities were growing for most measures related to access.
4. *Information about disparities is improving.* The 2005 NHDR provides more information about disparities than previous reports. In part, this is attributable to improving data available for assessing disparities.

There are still significant gaps in reporting racial and ethnic disparities at the state level and at the health plan level. According to America's Health Insurance Plans (AHIP),³ almost half of health plan enrollees surveyed belong to a health plan that does not collect data on race and ethnicity.

I am pleased to report that nine of the nation's largest health insurance plans have joined together to improve the capacity to collect and analyze data on race and ethnicities through the far-reaching National Health Plan Collaborative to Reduce Disparities and Improve Quality in Diabetes Care. These data are linked to quality measures, and they are developing quality improvement interventions to close gaps in care. Along with the Robert Wood Johnson Foundation, the Center for Health Care Strategies and the Institute for Healthcare Improvement, AHRQ is helping to fund and guide this collaborative. It is doing vitally important work to close the gap in the quality of diabetes care for African Americans, Hispanics, and Native Americans.

COMING SOON

This spring, two electronic tools based on the Reports will be released. A new State Snapshot Web tool will provide quick and easy access to the many

measures and tables of the Quality Report from each state's perspective. In addition, a new interactive tool that allows users to produce customized tables based on data gathered for the Reports also will be released.

In the 2006 Reports, we plan to add:

- New measures of the quality of care for asthma from the NCHS SLAITS National Asthma Survey
- New measures of the quality of care for obesity from MEPS and NHANES
- New measures of the quality of end-of-life care received by hospice patients from the National Hospice and Palliative Care Organization

The 2006 National Healthcare Disparities Report will include:

- An expanded section on cultural competency and language barriers to quality care, including new workforce diversity measures
- An expanded section on disparities experienced by persons with disabilities
- Work is also ongoing to develop measures of health care efficiency and to refine methods for summarizing disparities in care.

CONCLUSION: QUESTIONS RAISED BY THE TWO REPORTS

Not only do the two reports provide health services researchers with much needed data. They also raise a number of possible researchable questions, such as the following:

- Is the 2.8 percent overall annual improvement rate for quality acceptable, or should we seek more rapid improvement?
- Why has quality improved with respect to some measures and not others?
- Why are the timeliness and patient centeredness of care not improving at a faster pace?
- Why are disparities growing larger in some areas and smaller in others?
- Why are disparities increasing for some groups (especially Hispanics) and diminishing for others?

- Are the causes of disparities the same across all health care sites (e.g., hospitals, nursing homes, home health care, and ambulatory care)?
- What can we do to accelerate the pace of improvement for measures of both quality and disparities?

The readers of this journal are uniquely positioned to use these reports to build the foundation of evidence needed to eliminate disparities and improve the quality of health care. AHRQ is very pleased to continue to provide the data and information to support your efforts and help you achieve success.

NOTES

1. Percent of emergency department visits in which the patient left without being seen, and suicide deaths per 100,000 population.
2. Iowa, Maryland, Massachusetts, Minnesota, Vermont, and Wisconsin.
3. “Health Insurance Plans Address Disparities in Care: Highlights of a 2004 AHIP/RWJF Quantitative Survey Collection and Use of Data on Race and Ethnicity,” accessible at <http://www.ahip.org/content/default.aspx?bc=38|82|5859>