

Chapter 7. Conclusion

“A journey of a thousand miles must begin with a single step.”

Lao-tzu (604 BC - 531 BC)

This first National Healthcare Quality Report (NHQR) is not the first step on the journey to an improved U.S. health care system. Many other authors and organizations have already begun the effort to assess the quality of care nationally and improve it. However, this report is one important step on the road to national improvement in American health care delivery. The danger that must be averted is that we become so involved in the “journey,” the reporting on quality of care, that we do not do enough to ensure that this report, and others like it, are being used to accomplish our ultimate objective: to improve health care quality in America. In this section, we offer a summary of our key findings in reporting on health care quality in America, as well as a look forward to what comes next.

Summary

Key Findings:

- High quality health care is not yet a universal reality.
- Opportunities for preventive care are frequently missed.
- Management of chronic diseases presents unique quality challenges.
- There is more to learn.
- Greater improvement is possible.

High quality health care is not yet a universal reality in America. This report identifies many areas where there is a gap between what we know should be done and what patients and their providers continue to do. However, this report also identifies numerous areas where health care is improving to the point where we are close to reaching and surpassing national performance goals.

The report presents the most comprehensive national picture to date that confirms this observation. Levels of quality of care, across the variety of measures tracked in the report, vary for different aspects of health care and across regions, States, and patient groups. Quality also varies by demographic categories including age, sex, race, and ethnicity. Rates remain low for provision of some basic and cost-effective preventive care and disparities persist in quality of care for certain subgroups.

Despite this variation, quality of care has markedly improved and is now uniformly high in several notable areas. Moreover, best practices show us how to provide cost-effective, high quality care. In many of the efforts cited in this report as examples of best practices, the central role of data in quality improvement efforts is underscored. In many of the priority conditions and dimensions of quality presented in this report, we do not have a complete picture of our national performance. Ongoing work by private sector provider, payer, and research organizations as well

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as by public-sector entities, need to focus on filling in the gaps in our ability to measure quality in other areas.

With time, we will be able to answer such questions, but we expect that by drawing on existing measures and broad expert and public input, the report will promote consistency across multiple initiatives and will provide a template for selecting future national quality measures. Moreover, it is clear that this report is already making an impact at the State and national levels. Outreach conducted by AHRQ to State partners and to private-sector organizations has resulted in policy activities at the State and local levels to align State health care quality reports with the report framework and measure set. Such efforts can help to reduce the burden of quality measurement for providers and health care organizations and enable broader comparisons across our health care system. We expect these activities to continue as consensus activities continue for this report and for future reports. This report is expected to become a unifying tool for measurement and improvement activities in health care quality nationally as it is updated and improved in future quality reports. Finally, for the American health care system, the report will be a baseline to judge the future performance of the entire health care system.

The impact of the report will depend on how the information contained in this report is used. Currently, the picture of health care quality in America is fragmented and incomplete. With this first quality report, we are beginning the process of completing that picture.

What can be done now that this broad picture of health care quality in America has been painted? This report is built on the premise that in order to begin a journey you must know where you are going and have information on your progress. This report, we believe, provides us with information that will help us track our progress toward more effective, safe, timely, and patient-centered care. Future editions of this report will attempt to align more closely with Departmental priority areas.

This report provides information on a number of areas where improvement is being realized in the American health care system. These improvements are coming across the spectrum of care. For example:

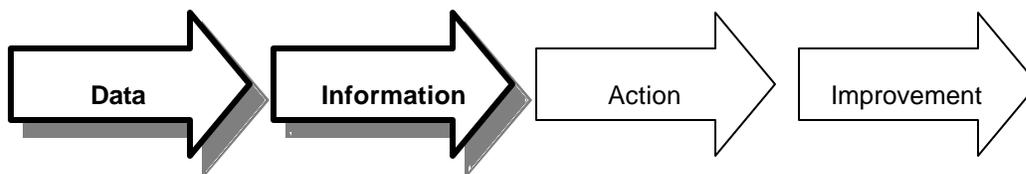
- **Staying healthy**: Screening rates for cervical and colorectal cancer have been increasing over the past decade, and cholesterol screening rates have greatly increased over the past two decades. Childhood immunizations continue to be high, and the Nation is doing better at ensuring that minorities are immunized at rates comparable to the rest of the population.
- **Getting better**: The percentage of patients who received beta-blockers when they were discharged from the hospital following a heart attack increased significantly between 1998 to 1999 and 2000 to 2001.
- **Living with illness**: We are doing a better job of helping diabetes patients manage their illness and stay out of the hospital. Hospital admissions for uncontrolled diabetes have decreased from 40.7 to 28.2 per 100,000 population in just 5 years from 1996 to 2000.

- **End of life care** : While better measures are needed in this area, the percentage of cancer patients who received hospice care increased significantly between 1996 and 1998 from 39% to 55%.

These are a few examples of improvement at a national level, but improvement at local and State levels is more common.

The report also highlights many areas where we are not making progress or where important groups are being left behind. Throughout the report, we have tried to highlight success stories and best practices that can help shed light on how to improve performance where it is lagging. It is hoped that the report will help to align the multiple efforts at quality measurement and thereby better focus national discussion on quality from measurement issues to improvement issues. While there are many models of how to improve quality within health care, a simple way of thinking of the role of this report in the process of improving care is shown in Figure 1.

Figure 1. What's next: The role of the NHQR



This report represents a large amount of work by a host of Federal and private partners to develop consensus on the important dimensions of quality, health conditions, aspects of care, and specific measures that will best give a picture of quality of care in America. The report represents the first step toward improvement as portrayed in Figure 1: that is, gathering and synthesizing data to turn it into information. What must happen next is the use of that information for action and improvement.

There may be numerous initiatives that result from the information in this report and future refinements to this report. Health care delivery changes every day as new technologies and methods are introduced. In such an evolving system, there is no single answer to improving quality. The mandate for this report is not to lay out a blueprint for how we should improve health care in America. Instead, there are several key steps in moving from data to improvement in health care. First, data must be understood and synthesized into information that is usable by decisionmakers, whether they are at the patient care level or the policy level. Second, information must be translated into action. One example of a program supported by AHRQ that is helping to translate data into action is the Translating Research in Practice program, or TRIP.

TRIP is a collaborative effort between AHRQ and the Health Services Research and Development Service (HSR&D) within the Department of Veterans Affairs (VA). Through the TRIP agenda, AHRQ sponsors applied research to develop sustainable and replicable models and

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tools to improve the quality, outcomes, effectiveness, efficiency, and cost-effectiveness of health care. For example:

- **Designing an Asthma Intervention for Resource Constrained Environments.**
Researchers led by Judith Fifield at the University of Connecticut planned to translate NAEPP (National Asthma Education and Prevention Program) guidelines using feedback and cues close to the time of decisionmaking and without increasing the length or the cost of the visit. Preliminary work with their target sites revealed that the sites did not have electronic medical record systems or plans to purchase such systems. Consequently, the project resulted in development of a model of technology that was affordable and flexible for implementation in the Medicaid managed care environment. The system supports TRIP as well as TRIP research. Instead of being redundant or time consuming, it is organized around “smart cues”—decision support reports that combine specifics about individual patients with best practices from NAEPP guidelines. The system includes computerized system support for screening, contacting, and tracking pediatric asthma patients, while simultaneously delivering smart cues to prompt practitioners to deliver guideline care. The technical design of the system is a client-server system which offers the advantages and integrity of a centralized Web-based database housed in a single locale, while supporting the requirements of multi-site data generation, data entry and reporting.¹
- **Overcoming resistance to pain management guidelines in nursing homes.**
Researchers led by Katherine Jones, of the University of Colorado, found that resistance to pain management guidelines occurred at multiple levels in nursing homes. Residents, staff, and physicians have attitude and knowledge gaps that pose barriers to guideline acceptance. Resident barriers include: dislike of multiple medications, fear of side effects and addiction to opioids, belief that pain is inevitable, feeling medication would be unavailable even if requested, belief the medication is ineffective, and concerns about bothering the nurses. Staff lacked information regarding pharmacologic management and the effectiveness of nonpharmacologic interventions, and they missed cues by stereotyping patients when assessing and treating pain. Physicians resisted the guidelines and did not want to change prescribing practices based on nursing home staff assessments. Through careful analysis of barriers to changes in practice, the intervention was able to address this resistance successfully and initiate improvements in guideline compliance.¹

This report is the first of its kind. As such, it is the first in a long journey toward improved health care quality. Future reports will be able to improve on the picture of quality offered in this report as consensus develops around new, better measures and new, more detailed quality data. The Department of Health and Human Services and the Agency for Healthcare Research and Quality look forward to feedback on this report and to improving future reports so that the NHQR can truly serve as a benchmark for quality for America’s health care system.

Reference

¹ Feifer C, Fifield J, Ornstein S, Karson A, Bates D, Jones K, Vargas P. Overcoming challenges to translating research into practice research. Submitted for publication, April 2003.

