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Testimony on Health Care Information Technology

before the

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Health Information Technology and Underserved Populations

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Mr. Chairman and Members of the Subcommittee, I am Dr. Carolyn Clancy, the Director of the Agency for Healthcare Research and Quality, known as AHRQ, a component of the Department of Health and Human Services. I would like to thank you for the opportunity to discuss the role that health information technology can play in improving the quality of health care for underserved populations in this Nation.

The mission of the Agency for Healthcare Research and Quality is to improve the quality, safety, effectiveness, and efficiency of health care for all Americans. As part of this mission, AHRQ has worked for many years to harness the power of health information technology to improve how health care is delivered, and ultimately, the health of the American people. To that end we work closely with the Office of the National Coordinator of Health IT and other Federal agencies to assure that our investments are closely aligned and concentrate specifically on the use of health information technology to improve safety and quality in diverse health care settings, with a strong focus on those organizations providing care to underserved and rural populations.

Inequities in Care

It is an understatement to say that health care quality in the United States is nowhere near as good as it could or should be. We also have wide racial, socioeconomic, and geographic inequities in how health care is delivered in this country.

According to research from RAND, partially funded by AHRQ, Americans have just a 50 percent chance of receiving the care they need when they go to a doctor's office. Other research indicates that as many as 1.5 million medication errors occur in hospitals each year; serious problems with health care quality exist in all areas in health care.

According to data from AHRQ's annual, congressionally mandated *National Health Care Quality Report,* health care quality improved just 3.1 percent in 2006 — the same rate of improvement as the previous 2 years. Data for these measures come from a variety of databases including CMS data, vital statistics, NHIS, and MEPS.

Its companion report, the *National Health Care Disparities Report*, found that access to high quality care varied widely between racial, ethnic and economic groups. This report focuses on a number of health care processes and outcomes that are useful for tracking quality of care. Of the 22 core measures that support comparisons across racial and ethnic groups, African Americans received poorer

quality care than whites for 73 percent of the core measures included in the disparities report. Hispanics received poorer quality of care than non-Hispanic whites for 77 percent of the measures. Poor people received lower quality of care than high-income people for 71 percent of the measures.

The Disparities Report also documents the quality of care for residents of rural America. We know that compared with their national counterparts, rural residents are more likely to be elderly, poor, in fair or poor health, and to have chronic conditions. Rural residents are less likely to receive recommended preventive services and report, on average, fewer visits to health care providers. Unfortunately, we do not have data specific to urban, underserved Americans.

Improving Health Care for All Americans

The good news is that we are working to resolve these quality problems and we are making progress.

According to AHRQ's quality and disparities reports, the greatest quality gains occurred in U.S. hospitals, where quality improved 7.8 percent. Ambulatory care—health services provided at doctors' offices, clinics or other settings without an overnight stay—improved by 3.2 percent. Nursing home and home health care improved by 1 percent.

The bad news is that this pace is slow, and it is even slower for minorities, the poor and other priority populations.

So how do we accelerate change? How do we engage all health care stakeholders to ensure that our Nation's citizens receive the highest quality, safest health care possible?

First, we must recognize, as HHS Secretary Mike Leavitt has said, that we don't have a health care ***system*** in the United States. We have a large, rapidly growing health care sector.

Then we need to find ways to connect the various parts of this sector to function more like a system, and an important connector is health information technology. It is important to note that health IT is not a magic bullet. It alone won't transform the health care system but it is impossible to envision that the transformation we need can occur without the capacities it brings.

Think for a moment about what is happening in health care settings around the country. Millions of decisions are being made about people's lives without the right information in hand:

- Is chemotherapy alone the best treatment for a patient with breast cancer, or should she be treated with radiation and chemotherapy?
- How do persons with diabetes, high blood pressure, and obesity manage all the different demands of their conditions?

Patients and consumers struggle with even more basic decisions:

- Which provider to see?

- When to seek care?
- Which treatment option is best for their needs?

Many of these decisions are difficult even in the most ideal circumstances, when there is sufficient time to assess good, reliable information. But as we all know, these decisions frequently must be made at times and places where information is not available, and time is of the essence. The power of health IT can help us to harness the power of large amounts of data to regularly assess quality and outcomes, and to put the analysis of the reliable data into the hands of a provider or patient in a usable format when they need it most - at the point of care or at when making decisions about care.

Health IT can be a tool to help bind our health care delivery sector together and bring much-needed information, services, and innovations to anyone who needs health care.

AHRQ, Health IT, and Underserved Populations

AHRQ's initiative on health information technology is a key element to the nation's 10-year strategy to bring health care into the 21st century by advancing the use of information technology.

The AHRQ initiative includes more than $166 million (FY 2004-FY2006) in grants and contracts in 41 states to support and stimulate investment in health IT, especially in rural and underserved areas. Through these and other projects,

AHRQ and its partners will identify challenges to health IT adoption and use, solutions and best practices for making health IT work, encourage the use of health information technology as a normal cost of doing business, and market-based tools that will help hospitals and clinicians successfully incorporate new IT.

Through this initiative, AHRQ is working to ensure that the promise and potential of health IT is available to all Americans.

More than 50 percent of AHRQ's health IT funding has targeted rural populations. From FY2004-FY2006, the amount spent for rural health IT projects totaled $75M.

Under our newly funded Ambulatory Safety and Quality Initiative, we are spending $6.5 million for health IT grants targeting priority populations of a total $21 million in grants in FY07. Mr. Chairman, we recently awarded one such grant – of nearly $700,000 – to the New York City Department of Health/Mental Hygiene to enable the meaningful measurement of the quality of care, with a focus on public health priority issues, disadvantaged populations, and small office practices.

This project will design and test a simple and intuitive "quality dashboard" suitable for small office practices that will integrate quality measurement and clinical decision support at the point of care.

AHRQ is very pleased to be collaborating with the Office of the National Coordinator of Health IT on the funding of a report to review and analyze the best clinical evidence on use of health IT by the underserved, elderly and disabled. The findings of this analysis will give us information we need to ensure that these populations reap the benefits of health IT.

States also play a critical role in all aspects of health care delivery. To that end, in FY2007, we also have funded a $3 million contract with Research Triangle Institute to provide technical assistance to up to 20 states on best use of health IT to improve the quality of healthcare for Medicaid and SCHIP beneficiaries.

Technical assistance is very critical to the successful adoption and implementation of health IT. To assure that as many Americans as possible benefit from our research, we have created a National Resource Center for Health IT.

The Resource Center leverages our investments in health IT by offering help where it's needed most in real world clinical settings that may feel ill-equipped to meet the implementation challenge. It facilitates expert and peer-to-peer collaborative learning and fosters the growth of online communities that are planning, implementing, and researching health IT.

AHRQ has also used the Resource Center to assist States that are initiating statewide clinical data sharing. We have convened small, round-table working

meetings of experts to share detailed expertise with States as they determine governance and technical architecture of their data-sharing organizations. We have met with many states, including New York, Wyoming, Montana, Delaware, Maryland, and Georgia.

The Resource Center provides a Web portal with capabilities to convene practitioners, encourage collaboration, and disseminate best practices. The portal gathers communities of practices with similar interests and concerns to share and learn. The Resource Center also supports a special portal for the nation's community health centers, providers in the Medicare health IT initiative, and the Indian Health Service, as they work to adopt health IT.

Lessons Learned

Mr. Chairman, I would like to conclude by offering a few brief observations based upon our work in health IT.

First, high quality health IT alone cannot improve our health care system unless it is integrated into the very fabric of care by incorporating systems into our individual clinical practices, hospitals and other settings.

Second, for most health care settings, health IT is not likely to create "out-of-the-box" solutions. Effective use of health IT begins with a careful examination of the health care setting and then uses the power of IT to enhance effectiveness and efficiency.

Third, accelerating the pace of health IT adoption and implementation, given the level of economic investment that would be required, requires the sharing of both knowledge and experience through additional opportunities for voluntary peer-to-peer learning.

Finally, the development of interoperable health IT can accelerate the pace of innovation and the speed with which patients will benefit from new medical breakthroughs. The inherent delays in our current system for assessing the effectiveness of new drugs, devices, and procedures could decrease dramatically with widespread use of health IT and advance our common goal of evidence-based medicine.

Conclusion

Mr. Chairman, thank you for the opportunity to update you on the progress we are making in the area of health IT, particularly for underserved populations. I am confident that working together, we can ensure that all American receive high-quality, safe health care services.