

## Conference Summary

# AHRQ Summit—Improving Health Care Quality for All Americans: Celebrating Success, Measuring Progress, Moving Forward

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The Agency for Healthcare Research and Quality (AHRQ) held its first Summit on health care quality and disparities on April 4, 2005, at the Renaissance Hotel in Washington, DC. More than 250 people in the forefront of health care delivery and quality improvement from both the public and private sectors came together to exchange information on “lessons learned” and address ways to improve health care quality and eliminate health disparities.

### Summit Goal

The goal of the first Quality Summit was to generate energy and exchange knowledge that can be translated into continued interactions among participants and beyond, through networks, meetings, and other communication mechanisms. Participants concluded that the challenge will be to keep exploring diverse ways to disseminate knowledge and generate continued momentum for pushing forward the Quality Challenge—to improve health care quality for all Americans.

### Summit Agenda

The day’s agenda was developed to:

- Assess where we are in addressing health care quality and disparities.
- Share recent lessons learned from policy, research, and practice.
- Highlight the link between improving health care quality and reducing health disparities.

The individual presentations and panel discussions highlighted important challenges and strategies for addressing health care quality and reducing disparities.

#### Individual Presentations

- “The Quality Challenge” by Carolyn Clancy, M.D.
- “Turning the Corner on Quality” by Donald Berwick, M.D., M.P.P.
- “Quit Digging Your Grave With a Knife and Fork” by the Honorable Mike Huckabee

#### Panel Presentations

- Promising Quality Improvement Initiatives: Reports From the Field
- Eliminating Health Care Disparities
- Promising National Initiatives

These presentations, summarized on the following pages, provide examples from the field, findings from the research, and lessons on leading by example.

# The Quality Challenge

*Carolyn Clancy, M.D.*

*Director*

*Agency for Healthcare Research and Quality*

*U.S. Department of Health and Human Services*

At AHRQ, quality is more than just part of our name. It identifies the role we play within the U.S. Department of Health and Human Services and is at the heart of everything we do to further our understanding of quality gaps and health disparities, uncover the evidence-based strategies to address them, and disseminate that knowledge as broadly as possible.

## **Huge gaps and variations in quality remain.**

In so many cases, we know in detail the kind of care we should be delivering, including the science-based evidence and measures needed to assure quality. Yet the gaps in quality are glaring—not only the gaps between high-performing States and low-performing ones, but more fundamentally, the gaps between what we know about improving quality and what we actually achieve. We do have evidence of rapid positive changes, for example, in nursing home quality. However, it is the exception, not the rule—especially in the area of health care disparities.

## **What can be measured can be improved.**

Today we are measuring health care quality as never before—and these measures provide a critical baseline that is pointing the public spotlight on important quality gaps and disparities across the Nation.

Both consumers and clinicians experience health care on a one-by-one basis, based on personal stories or individual patients. Quality measures show us general patterns that cannot be seen at the individual level. They show what is really at stake in terms of quality, gaps, and disparities—and the stakes are huge.

If we do not improve quality more rapidly, our health care system will hardly be prepared to deliver the health care of the future.

The second annual National Healthcare Quality Report and National Healthcare Disparities Report, issued by AHRQ in February 2005, present the most extensive ongoing examination of quality and disparities.\* These reports indicate that a large gap remains between high-quality and low-quality care and that disparities remain entrenched. For example:

- State-by-State comparisons indicate that the percentages of women receiving prenatal care in the first trimester vary from 91 to 69 percent from the lowest performing States to the highest performing States.
- Rates of colon cancer screening for adults over age 50 range from 38 to 66 percent.

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\* The 2004 National Healthcare Quality Report and National Healthcare Disparities Report, including all detailed appendixes, can be accessed online at [www.qualitytools.ahrq.gov](http://www.qualitytools.ahrq.gov).

- Prompt administration of antibiotics for older patients with pneumonia ranges from 46 to 77 percent.

The data also indicate that even in States where the rates are higher, they often remain well below the standard of quality. Thus, there is need for improvement everywhere.

### **We must step up the rate of progress.**

Of 98 measures with trend data tracked in the National Healthcare Quality Report, the median rate of change was only 2.8 percent compared to the first report issued last year. Of these 98 measures:

- 67 measures saw some improvement.
- 30 indicators were worse this year than last.
- 1 measure remained unchanged.

At this rate of progress, it will take 20 years to achieve the desired levels of quality improvements.

### **Awareness of the importance of quality improvements is gaining attention.**

Here are just a few examples of recent national initiatives:

- The Centers for Medicare & Medicaid Services just released strong, comparative hospital quality data.
- AHRQ released its second annual report on health care quality and disparities.
- The Institute for Healthcare Improvement, led by Don Berwick, has launched a new 100K Lives Campaign—with specific goals to improve health care quality and reduce unnecessary deaths across the country.
- Policymakers in Congress are beginning to understand the association between quality and cost-effectiveness in health care. The Medicare Modernization Act includes many provisions that build on quality measurements—including the charge to AHRQ to study the comparative effectiveness of treatments for 10 key medical conditions.

These comparisons are critical. What athlete ever broke a performance record without knowing what the record was? Comparison is part of the process of turning information into action.

### **Measurement is critical, but it is not enough.**

We must translate information into action. The challenge is to disseminate knowledge and best practices broadly and in formats that are easy to access and use.

We know that the closer we come to the source of care, the more actionable our information becomes. We need to help clinicians and health care systems learn the evidence-based facts about best practices. And they need to make the system changes that put knowledge into practice.

At AHRQ, we are trying to make our data more useful to States, communities, and practitioners—especially by making them more targeted. We are offering a new presentation of our data for 14 key health indicators which are now broken down by State.\*

This is meant to be a tool (not a grade) that States can use to clarify areas of strength and weakness. In addition, AHRQ is interested in hearing from States regarding what other types of technical assistance would help them.

Much is happening at the local level. Islands of innovation are everywhere. Hospitals, doctors, nurses, and other clinicians are developing novel solutions. By focusing on their own priority areas in their own communities and clinics, they are finding creative, real-world solutions that work.

In response, AHRQ is launching a new million-dollar initiative called AHRQ QualityConnect to help shine the light on what works and share lessons learned with those on the front lines of improvement. This is critical. We need to build bridges. We need to find where successful innovations have been made and share these new approaches widely.

Our goal is to share information on innovations and promising practices, on leaders in the field, and on useful tools and ideas through multiple communications methods such as meetings, the Web, research networks, and other forms of outreach.

### **A critical Quality Challenge lies before us.**

This requires a new attitude toward our mission and our profession. What is the Quality Challenge?

It is a challenge that is being carried out in the Medicare program, which is tracking and publishing quality data to drive improvements in health care facilities. It is the challenge that was launched by the Institute of Medicine report on medical errors that called for openness regarding quality issues and shared accountability for improvements.

The Quality Challenge can be described using five Cs:

- **Candor**—We must find the data on quality and disparities and share them openly.
- **Comparison**—Both patients and clinicians need to be able to compare providers and facilities to find and spur quality services.
- **Consequences**—The consequence of consumer and payer choice is that when quality shortcomings become known, it drives demand for improvement, forcing providers to find the energy and knowhow to correct problems.
- **Courage**—The Quality Challenge is not easy. Incorporating the features of candor, comparison, and consequences will require a culture change among health care providers. Courage is perhaps what is most needed to make the rest possible. Let's acknowledge that all

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\* These State data resources are available online at [www.qualitytools.ahrq.gov/qualityreport/state](http://www.qualitytools.ahrq.gov/qualityreport/state). For a list of additional AHRQ resources to facilitate quality improvement efforts, see [www.ahrq.gov/qual/resources.htm](http://www.ahrq.gov/qual/resources.htm).

over this country, health care professionals are demonstrating that they have the courage to improve.

- **Cooperation**—We must build bridges that connect successful innovations with those on the front lines of improvement, who are looking for creative models and lessons learned.

### **The challenge is great and raises the question, “Where do we go from here?”**

- We need to maintain constant focus, not only nationally but also in our community and clinical settings.
- We need to acknowledge the power of the metrics. We have built a new vocabulary of quality measurement and must incorporate the language of quality comparison and improvement into every health care setting.
- We need to use the power of health information technology to measure performance, make treatment information available, and make available complete patient information.
- We need the leadership of health care settings to be directly and visibly committed to health care improvement.
- We need to understand the central importance of health care disparities and the importance of improving provider communications to help tackle this problem.
- We need to keep improving our knowledge of what works best in health care, incorporating effectiveness research and ensuring that quality measures are kept up to date to reflect the latest findings.
- We need to understand the complexity of quality improvement; the major transformations it requires, and the importance of maintaining consistent scorecards, such as AHRQ’s quality reports.
- We need to appreciate the full meaning of patient-centeredness, which goes beyond patient needs and incorporates what patients themselves see as quality of care.
- We need to recognize the importance of professional pride among everyone in our health care system. In the end, it is personal vision, professionalism, and courage that will drive quality improvement.

This meeting is an important beginning. It has brought individuals who focus on quality together with those that focus on disparities. At AHRQ, we plan to follow up this conference with a series of town hall meetings to continue the discussion and information sharing. Our hope is that the dialog, research, promising practices, and exchange of information on lessons learned will continue.

Only by meeting the Quality Challenge can we ensure that every dollar we invest in health care buys a dollar’s worth of value and that Americans actually receive the best quality health care.

## Turning the Corner on Quality

*Donald M. Berwick, M.D., M.P.P.  
President and Chief Executive Officer  
Institute for Healthcare Improvement*

The Institute for Healthcare Improvement looks at the issue of quality on a worldwide level, underscoring even more critically the huge gaps we face.

### **It is hard to improve what we cannot see.**

The quality and disparity reports are turning an essential public light on the status of health care in the United States, including huge gaps not only within our Nation but, even more strikingly, in comparison to other industrialized countries.

Many organizations and agencies are to be commended for drawing national attention to the issues of health care quality and disparities:

- AHRQ for its seminal reports on health care quality and disparities, and Dr. Clancy for her leadership in the field.
- The Commonwealth Fund for the way it has captured public information on health care performance.
- The Centers for Medicare & Medicaid Services for making comparisons available to the public on its Web site.
- The Institute of Medicine (IOM) for its leadership in driving the discussion of quality gaps and medical errors.
- The National Quality Forum for its new standards of quality performance.

International comparisons really drive the point home of embarrassing gaps in U.S. health care. A study by the Commonwealth Fund reveals that the United States ranks last on measures of safety, efficiency, effectiveness, and equity compared to the other industrialized, English-speaking countries of Australia, Canada, New Zealand, and the United Kingdom. We must admit this first if we are to make progress.

### **We need new, more robust theories to change habits.**

Our Nation is at a turning point. Quality measures have advanced the battle toward quality improvement. However, this is only the first step in a long war. True improvement will require fundamental changes in the theories, practices, and behaviors that drive the way we provide health care in this country.

Some of the dominant theories that drive our health care system are either inaccurate or not powerful enough to drive the type of change needed to improve quality and reduce gaps. We must turn away from the theory that pushes the costs of efficiency and quality on to the consumer—a solution that is both unethical and unscientific.

To address health care quality and disparities requires a fundamental redistribution of wealth nationwide and should not be put on the backs of individual consumers or providers.

Similarly, we cannot rely on systems that offer providers more money to try harder. The vast majority of providers are dedicated and hard working; they need payment mechanisms designed to support their performance not to promote it.

In order to improve quality, we must have:

- Transparency.
- Specific, clear goals for improvement.
- Leadership from the top ranks of our health care sector dedicated to advancing those goals.
- Greater technical assistance to share improved knowledge of how to improve quality.

We are not there yet but can look to the past for successful examples, such as the Clean Air Act. The 1999 IOM report on medical errors set benchmarks and the challenge to reduce medical errors by 50 percent. To date, however, only the Department of Veterans Affairs has adopted this challenge.

We need greater involvement from leaders in the medical community, not just from doctors but from boards of trustees and stewards of health care organizations. These are the people who must adopt goals and place them up front and center. We must also set standards as a Nation with tighter consequences to drive improvement.

In addition, we need to promote more technical assistance. The improvement of knowledge must become a public good. We cannot afford to keep reinventing the wheel.

We must identify and share better knowledge and understanding of ways to improve quality. Once shared, that knowledge must be applied consistently and reliably. We cannot have variability across practices.

### **When we value the patient at the center of care, things get better.**

When the patient is at the center of care, everything improves—quality, outcomes, and even costs. However, redesigning delivery systems to be truly patient centered requires subversive change:

- It requires radical shifts in the way health care professionals work.
- It means we must cede the autonomy of individual health care specialties and professions.
- It means we must place the value on cooperation between providers—a cooperation built around one primary concern, the patient.

This is a real challenge—to value cooperation without suboptimizing individual health care professions.

## **We can improve health care quality and outcomes significantly.**

We can turn the corner. We have the science-based methods from AHRQ and models of successful projects.

Eight months ago, the Iowa Healthcare Collaborative (IHC) called together its staff, looked at successful methods and programs, and translated that information into a new health care improvement campaign. Called the 100K Lives Campaign, it was based on a list of goals to reduce avoidable deaths, pain, and waiting that the IHC referred to as the “no needless” list.

The goal of the 100K Lives Campaign is to avoid 100,000 needless deaths by June 14, 2006. It institutes a set of science-based standards that AHRQ-supported research has shown to reduce unnecessary deaths. These include:

- Using rapid response teams in hospitals.
- Making cardiac infarction care reliable with correct drug and procedure standards.
- Reducing adverse drug events, especially when patients are transferred from one unit or facility to another.
- Reducing hospital-based infections.
- Raising the angle of hospital beds for patients to avoid ventilator-associated pneumonia.
- Instituting measures for patients who are immobilized to avoid pressure ulcers.

Evidence indicates that if 200 hospitals use these methods, 100,000 deaths can be averted; thus, this was the goal of the campaign. However, the response to this campaign has been far greater than anticipated. To date, 1,700 hospitals have enrolled in the campaign; and by the end of April 2005, enrollment is expected to top 2,000.

## **The 100K Lives Campaign shows that health care providers are open to change.**

The huge response to the 100K Lives Campaign demonstrates the degree to which hospitals and health care staff are open to positive goals, help, achievement, trust, and learning. They are eager to adopt positive changes that they can implement and understand.

Along with the hospitals that have enrolled in the program, numerous national organizations have signed onto it, such as the American Medical Association, American Nurses Association, Department of Veterans Affairs, other Federal agencies, and several large hospital systems.

## **Questions and Discussion**

- *Are there common themes from the 100K Lives Campaign that can help inform the debate as to whether or not we are at a turning point regarding health care quality in this country?*

The huge response to the campaign is unusually promising and suggests we are at a turning point. In addition, three themes have emerged from the responses and inquiries we get regarding the campaign:



- There is extraordinary curiosity and interest in the details of how to improve quality and institute standards and practices on a practical level.
- There is a recognition that we must maintain focus—on quality and on improvements.
- The lights really are turning on among executive level leaders in hospitals and health care systems.

- *How do we implement successful theories of change?*

It is a great challenge to get an industry of this size to learn and change. We need to spread the knowledge of how to implement standards and improvement. We need to find new ways to communicate within organizations. We must see learning as a fundamental asset.

- *How do we get the message of health care quality improvement into medical education and training?*

Although academic health centers are often accused of being slow to change, this is an unfair assessment. There is good leadership within these institutions that is open to change. The key to change in education is the establishment of new competencies focused on practice-based learning and systems-based practice. However, it is important to note that changes in education will affect future practices; we need more immediate change now, too.

- *Should we be recording information on infections and how to prevent them?*

The Institute for Healthcare Improvement is interested in looking at new areas for progress. Infection should be one. We have the science on hand. The Centers for Disease Control and Prevention have the answers, and the data definitions are available as a public good.

There are excellent examples of continuous improvement philosophies from other industries, such as the automotive industry. They address ways to increase process improvements by looking at who is responsible for the system.

In the health care sector, if you look at who is responsible for the system, one of the answers is the board of trustees. And if you look at who is on the boards of trustees of major hospitals and health institutions, many of them are also members of local chambers of commerce and the National Association for Manufacturers.

We need to reach out to these groups, invite them to meetings such as this one, and get their members informed and involved to apply pressure for change.

# Quit Digging Your Grave With a Knife and Fork

*The Honorable Mike Huckabee*  
*Governor of Arkansas*

Improving the health care of the people of Arkansas, and our Nation, has become a personal passion and pilgrimage—one I have translated into public policy goals for reducing poor health behaviors among the children and adults of my State.

The State of Arkansas is one of the unhealthiest in the Nation. This is a threat not only to the personal health of each child and adult in our State but also to the financial health of Arkansas, because the costs related to treating the health problems associated with unhealthy behaviors are enormous.

As a result, we have instituted the Healthier Arkansas Initiative, targeting unhealthy behaviors that put our children and adults at risk. The initiative includes:

- Payments for preventive services, such as body mass index measures for school children.
- Information for parents and children on the health implications of unhealthy behaviors.

We have also developed a new set of health goals for our State. By 2006, we aim to:

- Reduce the rates of smoking in adults by one-half.
- Reduce the rates of obesity in children and adults by one-half.
- Double the rates of exercise and physical activity in adults.
- Increase the rates of exercise among children by one-third.

## **Our Nation is creating an epidemic of obesity and poor health.**

Our Nation is facing a terrible health crisis, and it is one of our own making. We are digging our own graves with a knife and fork—and creating an epidemic of obesity and poor health that threatens to bankrupt our Nation and reduce life expectancies for the first time in history.

As a person who grew up in the South and in a poor family, I understand the cultural, economic, and religious norms that drive our eating behaviors—where food is at the heart of social interactions; food choices are dictated by limited choices; and a thin piece of meat is battered, fried, and covered in gravy to stretch it further.

I was a product of those norms—of poor eating habits and a total aversion to exercise that had me in such bad physical shape that I could not walk up a flight of stairs or go a city block without being in pain and covered in sweat.

At 280 pounds (110 pounds more than today) with high blood pressure, chest pains, and a diagnosis of diabetes, my doctor warned me I would not live to see my 50<sup>th</sup> birthday.

Today I am living proof that a person truly can change his or her health, starting from a point of terrible shape and health habits and making his or her way to completing a marathon race. I know that you can replace the bad habits of a lifetime.

It is not just about going on a diet. I have tried them all, and they are not sustainable. It is about changing behaviors regarding food and physical activity and understanding that while every diet ends, health and fitness can last a lifetime.

### **We need to develop a culture of health.**

We need to develop a culture of health, not one that infringes on personal rights but one that helps us make choices that can improve individual lives as well as the financial and health conditions of our Nation.

Our health care system is broken. It throws money at treating chronic and preventable diseases but does not invest in preventing those conditions. For example, my insurance plan will pay for the enormous costs of a quadruple bypass surgery, but it will not cover the cost of a 30-minute appointment with a nutrition counselor.

We cannot sustain a system that is built on just finding and treating disease. We must attack the causes of disease, such as obesity, tobacco addiction, and lack of exercise. We must build positive incentives into our system—for example, changing the Food Stamp Program to associate monetary value with food value, thereby offering more money for healthier foods.

### **Poor health habits are a huge economic burden.**

One way to get policy leaders involved in promoting a new culture of health is to present it to them as an economic issue. States like Arkansas are currently being overwhelmed by health care costs and Medicaid budgets. If we can get Americans to change to healthier habits, we can change the economy of the United States.

### **To implement changes that lead to improvements, we must set measurable goals.**

Each State needs to develop a plan for improvement and establish measurable targets. Then it needs to analyze, measure, and announce the results of where it stands regarding health goals.

We must keep score. We expect to know the score in sports events—we cannot accept not to know the score in something as important as the health of our citizens.

## **Panel 1—Promising Quality Improvement Initiatives: Reports From the Field**

### **G.A. Carmichael Family Health Center**

*Janice Bacon, M.D.*

*Director of Clinical Services*

*The experience of the Carmichael Family Health Center in Canton, MS, demonstrates that consistent measurement of clinic-wide data and close management of patients can improve health care outcomes.*

The Carmichael Family Health Center's service area covers three towns in rural Mississippi. Ninety-two percent of the patients are African American, and 40 percent are uninsured. Thus they are working with a population that represents some of the people with the highest risk factors and lowest health outcomes in our Nation. The Center is governed by a Community Board of Directors, 80 percent of whom are users of the Center's services.

#### **The Center established a quality management strategy.**

As part of a health disparities collaborative sponsored by the Health Resources and Services Administration, the Carmichael Family Health Center established a quality management strategy focused on:

- Promoting positive health outcomes.
- Developing an informed team that interacts with a proactive patient.
- Building capacity for quality improvement.
- Redesigning systems.
- Building stronger risk management.

#### **Quality improvements for chronic and disabling conditions were targeted.**

To address some of the most important chronic and disabling conditions affecting their service community, the Center specifically targeted quality improvements for diabetes and asthma prevention, treatment, and detection.

In order to assess these conditions and determine the magnitude of the problem, the Center built a registry to collect baseline data on both of these conditions. The goal of the registry was to help determine not only rates of diabetes, but also how well patients were managing their condition.

The Center worked with the State diabetes prevention office, the State cardiovascular division, and eye care provider groups to set a quality management strategy, including targeted patient management, based on clear, evidence-based guidelines for treatment. They worked in partnership with local providers, churches, and other community resources to help increase awareness of the program, do outreach, and ensure that patients would be able to get to the health care center.

Since these quality improvement measures have been in place, the Center has seen improvements in HbA1c levels, which at baseline were on average twice the recommended rate, while expanding the number of patients entered into the diabetes registry. The asthma data have shown large improvements in the use of anti-inflammatory medications and in the use of patient self-management tools.

With consistent measures and guidelines along with targeted patient management, the Center has experience improved outcomes. As a result, it has garnered increasing support from local providers, including those who were reluctant to participate in these programs.

### **Community-wide support is critical.**

Community-wide support has been critical to the implementation and successes of the Carmichael Family Health Center's quality improvement initiative.

Many of the most important lessons and successes to come from this initiative are directly related to the Center's level of outreach and support with the local community and with provider organizations across the State:

- The Carmichael Family Health Center worked with State-level offices and providers to set standards.
- They invited local officials such as mayors and sheriffs to attend health fairs, boosting the profiles of these events.
- The Center brought in specialists such as nephrologists and cardiologists (usually accessible only in major cities) for onsite evaluations.
- They worked with local churches, the Ministerial Alliance, daycare centers, schools, and other organizations to address health barriers and to institute programs promoting healthy behaviors (e.g., dance exercise classes for students, parents, and teachers).

### **Centers must work with State and local partners and provider organizations.**

Lessons learned from the Carmichael Family Health Center experience include:

- Centers cannot function in isolation and must reach out.
- Centers must keep trying, be proactive, and remember 'it never hurts to ask.'
- It is important to be creative and to use both traditional and nontraditional partners.

## **Strong Memorial Hospital**

*Robert J. Panzer, M.D.  
Chief Quality Officer*

*By focusing on quality improvement and instituting specific procedures, this high-volume hospital has achieved strong positive outcomes, particularly related to ventilator-associated pneumonia (VAP).*

Strong Memorial Hospital operates 739 beds and serves a region of Upstate New York with a population of 1.7 million. The hospital has experienced enormous growth and operates at 94 percent of capacity.

The hospital's goals for success and improvement involve doing things right the first time to avoid errors as well as optimizing safety, satisfaction, costs, and clinical outcomes.

To meet these goals, the hospital instituted new procedures, including:

- Daily goal sheets for each patient.
- New protocols and standards for the care team.
- Monthly safety walkarounds for senior leaders.
- Clear guidelines for flow in and out of the intensive care unit.

### **New protocols were instituted to reduce risk of ventilator-associated pneumonia.**

As a result of these new prevention protocols, the Strong Memorial Hospital experienced a significant and rapid improvement in results for ventilator-associated pneumonia (VAP):

- There was a reduction in VAP from 6 percent to less than 1 percent.
- This translated to a 27.5-percent reduction in VAP morbidity and 14-percent reduction in excess mortality from VAP.
- Since the estimated cost of a VAP ranges from \$5,000 to \$27,000, the cost savings each year from the reduced number of VAPs was between \$137,000 and \$742,500.

### **Computer technology was initiated to reduce risk of venous thromboembolism.**

Strong Memorial Hospital also joined with four others in the Rochester Regional Thromboembolism Collaborative to institute a computerized provider order entry (CPOE) technology; its aim was to reduce the risk of venous thromboembolism. The CPOE technology was adapted to be user friendly for hospital staff and more convenient than the old paper system.

The electronic form offers both risk assessment and prophylaxis choices, and it is used as a routine part of admission orders for all patients. As a result of this initiative, the appropriate use of prophylaxis was significantly improved over a 14-month period across each of the participating hospitals.

**A focus on quality improvement can lead to positive outcomes relatively soon.**

By instituting clear, simple, and relatively inexpensive procedures, we can achieve the following within a remarkably short period of time:

- Improved communications.
- Fewer errors.
- Significantly increased positive outcomes.

**Lumetra** (San Francisco, CA)  
Jo Ellen H. Ross, M.N.A.  
President and CEO

*The 2-year Doctors Office Quality-Information Technology (DOQ-IT) project fosters use of an electronic health records system instead of a paper-based structure to promote efficiency and improve quality.*

Research indicates that among outpatient visits, 13.6 percent of essential patient information is missed.\* This includes such data as lab results, letters and dictation, radiology results, information on medications, history, and physical examination.

The goal of the DOQ-IT project is to use an electronic-based health records system to limit this problem and accelerate the rate of quality improvement in physicians' offices.

The DOQ-IT pilot study investigates barriers and opportunities for the adoption of electronic health records systems in physician's offices. Supported by the Centers for Medicare & Medicaid Services, this study has been undertaken by four quality improvement organizations (QIOs) located in California, Arkansas, Massachusetts, and Utah.

Other partners include:

- American Academy of Family Physicians.
- American Medical Association.
- American Academy of Family Practices.
- American Osteopathic Association.
- Medical Group Management Association.
- Medical Records Institute.
- Other health system organizations.

**An objective of the DOQ-IT project is to promote efficiency and improve safety.**

The pilot program targets small and medium-sized practices and aims to use the electronic health records technology to help develop and implement the QIO intervention model for improved chronic and preventive care management in primary care practices. The program's objectives are to help make physician's offices more efficient by using electronic patient records and to improve patient safety and outcomes.

The DOQ-IT project offers support to practices interested in adopting electronic health records in areas such as:

- Guidance on office redesign needs.
- Functionality requirements for the technology.

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\* Smith PC, Araya-Guerra R, Bublitz C, et al. Missing clinical information during primary care visits. JAMA. 2005 Feb 2;293 (5):565-71.



- Implementation planning.
- Interoperability considerations.
- Quality improvement processes.
- Choices of vendors.
- Preparation for pay-for-performance data collection.

It also provides advice regarding the types of culture and leadership changes that may need to accompany the adoption of this new technology.

### **Response to the DOQ-IT program has been higher than anticipated.**

Many physicians are very interested in adopting tools to improve quality and efficiency within their practices.

Participation in the DOQ-IT program is voluntary and free of charge, but it also requires that physicians' practices commit to the following:

- Completing a readiness assessment.
- Selecting and acquiring an electronic health records system.
- Making the necessary office redesign and systems changes to adopt the program.

Another important requirement of the program is that practices adopt a quality improvement project using this technology; this may include such things as creating a diabetes registry system, implementing patient self-management tools, or customizing visit templates for chronic diseases.

### **Improved quality and efficiency offer practices an important return on investment.**

Among the lessons learned from the DOQ-IT project are:

- Moving from a paper-based to an electronic records system is challenging because it requires cultural change, office redesign, and financial investment.
- The level of interest from physicians' practices is very high.
- The payoffs in terms of improved quality and efficiency offer an important return on investment.
- QIOs represent a great resource for physicians' practices.

## **Sentara Healthcare**

*Gary R. Yates, M.D.  
Chief Medical Officer*

*To improve health care quality and patient safety, health care institutions must change their whole environment and create a new culture of quality that will serve as a foundation for progress and change.*

In order to improve quality and safety, health care organizations must develop a framework comprised of four critical dimensions:

- **Technology**—Incorporate important information and decision supports into processes at points of care. For example, the use of remote electronic links in the intensive care unit to add an extra level of offsite vigilance remotely has been shown to decrease mortality rates by 20 percent.
- **Processes**—Create more reliable processes built on principles of human factors research.
- **People**—Recruit, train, grow, and retain a capable and reliable workforce.
- **Culture**—Adopt a strong culture based on safety and excellence that will provide the foundation for improved quality and safety.

Changing the culture of health care is like reaching the high C in music—it is the hardest goal to achieve.

### **The health care industry can learn from other business sectors.**

In looking for useful techniques and examples of how to change direction and accelerate the pace of improvement, the health care industry has much to learn from other business sectors.

Sentara (Norfolk, VA) searched beyond the health care sector for assistance and made use of some of the safety and quality approaches that have been developed for the nuclear power industry. They conducted a baseline analysis, with input from providers, of strengths and opportunities, identifying four key risk areas that contributed to 90 percent of problems:

- Inadequate communications, particularly during changes (e.g., shift changes, transfer of patients to different units).
- Inadequate attention to detail.
- Noncompliance with policy and procedures.
- Use of high-risk behaviors (often not recognized as such) in high-risk situations.

Changing the institutional culture requires clearly stated changes in processes, behaviors, and expectations. Staff and providers must be given the tools with which to change. It is not enough simply to tell them to do better.

### **Changing institutional culture requires clear, behavior-based expectations.**

To inculcate a culture of quality throughout the organization, Sentara established a new set of behavior-based expectations aimed at both general approaches and specific problem areas. These

expectations were developed by a team of 25 members that included representatives from the medical staff, managers, and other employees.

Examples of some of these behavior-based expectations, designed to address the problem areas identified in the baseline review, include the following:

- **Pay attention to detail**—Sentara adopted a technique from the nuclear power industry known as SAFE:
  - Stop.
  - Assess.
  - Focus.
  - Evaluate.It takes just over 3 minutes to implement.
- **Have a questioning attitude**—Verify and validate.
- **Hand off effectively**—Ensure that proper information is passed along when patients are transferred or provider shifts change. Use the five Ps:
  - Patient.
  - Plan.
  - Purpose.
  - Problems.
  - Precautions.
- **Assign a coordinating physician**—This is the captain of the ship.

After instituting clear, quality-based guidelines with the behavior-based expectations, Sentara experienced the following:

- A 21-percent increase in effective handoffs.
- A 42-percent reduction in falls with injury.
- A 38-percent decrease in hospital-acquired pressure ulcers.
- Significant reductions in liability claims.

This experience suggests that with the institution of clear, consistent guidelines, we can accelerate the pace of improvement and build a solid organizational foundation based on quality and safety.

## **Panel 2—Eliminating Health Care Disparities**

### **Office of Minority Health**

*Garth N. Graham, M.D., M.P.H.*

*Deputy Assistant Secretary for Minority Health*

*Department of Health and Human Services*

*The Office of Minority Health reaches across the leadership levels of other agencies in the Department of Health and Human Services to address health care disparities with a community-based focus.*

The issue of health care disparities was first raised to national attention in 1985 with the publication of a landmark report on black and minority health by Margaret Heckler. That report prompted the development of the Office on Minority Health (OMH).

Since the founding of the Office of Minority Health in 1985, we have made significant strides in integrating the lexicon of disparities into public health and improving health outcomes for minorities. However, important disparities remain.

### **We must continue to link the issue of disparities with that of health care quality.**

Today, we can look back at the changes and remaining challenges that face us 20 years later. One of the lessons we draw from those comparisons is that we must continue to link the issue of disparities with that of health care quality. We cannot solve one without the other.

OMH is very grassroots based and has a community-based focus. Its role is to coordinate minority health issues and activities across the entire Department.

The Department of Health and Human Services oversees a budget that is equivalent to the national budgets of many countries. We are an enormous force, and we understand the strength of reaching across agencies to partner and develop a strategic mission for addressing disparities.

### **OMH has developed a 20-year strategic plan to address health care disparities.**

With high-level members across the agencies, OMH has developed a strategic plan to address the next 20 years. It includes:

- Improved data collection on race and ethnicity across the Department.
- Better information dissemination to minority communities.
- Increased cultural competence and health literacy.
- Greater workforce diversity among health care providers.
- Greater use of information technologies, practical tools, and capabilities.

## **American Medical Association**

*John C. Nelson, M.D., M.P.H., FACOB, FACPM  
President and Executive Committee Member*

*Individual physicians need to take on issues of health care quality and disparities in their own practices and recognize the importance of culture and diversity in their encounters with patients.*

We must make physicians understand that issues regarding health care quality and disparities are not someone else's problem. They must be confronted by every doctor in his or her own practice.

### **Ethics demand that we do something about health disparities.**

Our model of medical practice involves three interlocking circles which represent ethics, evidence base, and caring about patients. The Commission to End Health Care Disparities, sponsored by 37 different medical organizations, is dedicated to integrating the recognition of health disparities into this model—using evidence-based knowledge to give physicians the knowledge and tools for identifying disparities in their own practices.

Change must happen at the level of the individual practitioner as well. We must motivate our colleagues to bring about transformations in their own practices so that disparities become a thing of the past.

We need to challenge individual physicians to recognize and be sensitive to the importance of culture and diversity in their daily encounters with patients. We must recognize disparities within our own patient base, love our patients, and transform our practices to take on the issue of health disparities.

### **Past discrimination and exclusionism must be recognized and corrected.**

In 1895, the National Medical Association was formed because the American Medical Association refused to admit African Americans. I would like to offer an apology, on behalf of the AMA, for its onetime policy of excluding black physicians.

## **National Hispanic Medical Association**

*Elena Rios, M.D., M.S.P.H.*

*President*

*The National Hispanic Medical Association is creating a common network through which Hispanic health care providers can address health policies and disparities to improve the health of Latinos.*

Latinos represent 2-5 percent of the U.S. population of nurses, dentists, doctors, and other health care providers. While they represent a great diversity of Hispanic populations and cultures, they are now coming together in a common network to address health policies and disparities to improve the health of Latinos.

Although representing only a small proportion of the total population, there are many Hispanic physicians in the United States. This generation of providers represents the first critical mass of Hispanic doctors to have been educated in this country. There are few role models within this group, and the ones that do exist need to be supported to promote leadership.

The National Hispanic Medical Association taking up the challenges of the AHRQ quality and disparities reports. Its mission is to improve the health of Hispanics and the underserved.

The Association collaborates with the Hispanic Students Association and the more than 20 different Hispanic medical societies around the country to:

- Build a common network so that Hispanic health care providers can address the challenges of the AHRQ quality and disparities reports with a common voice.
- Promote leadership among Hispanic students and providers.
- Encourage students and residents interested in careers in health care services research.

The National Hispanic Medical Association is also promoting increased awareness of Hispanic health issues among non-Hispanic providers by sharing approaches that have been shown to work in Latino communities in the United States.

## **Commission To End Health Care Disparities**

*Randall W. Maxey, M.D., Ph.D.*

*Co-Chair*

*Health care disparities must be placed in a broader context of socioeconomic disparities, racism, culture, empowerment, and family life.*

Health care disparities are just the tip of the iceberg. They are a sign of broader socioeconomic issues and of equally important issues of culture, family, and empowerment:

- We must focus on disease prevention and health promotion.
- We must look among families, parents, and communities to see what else we can do to address disparities.
- We must remember that parenting is one of the most important pieces of health protection.

The Health Education and Risk Reduction Opportunities Project, or HERRO, is counseling and working with parents to address food and lifestyle behaviors to promote healthier lives.

### **Nothing happens simply because we generate data.**

If, in 5 years, all we have to show for our efforts are more data, we will have failed. The data are just a jumping-off point. We need more involvement from minorities to cull out the data from these quality and disparity reports, analyze evidence-based findings, and address real change.

We do not have a national body to mandate change, so we need to get down to the actual practice level, with examples such as the use of different beta-blockers which are more effective in certain populations.

We need to bring in policymakers to make change happen. We need coalitions of people to affect change.

### **Fear and good health do not exist in the same place.**

Unfortunately, fear is pervasive in the black community due to racism and discrimination. I can say this as both a physician and a patient who has had to face radical treatment for prostate cancer.

As young revolutionary angry with the American Medical Association's (AMA's) exclusion of black physicians, I recognize and appreciate the enormous importance of John's apology on behalf of the AMA for its former discrimination against black physicians.

## **Discussion**

### **The strategy for addressing disparities must go beyond socioeconomic status.**

We cannot simply use low socioeconomic status (SES) and financial vulnerability as a strategy for addressing disparities. Although low SES correlates with race and ethnicity, if you use SES only as a defining factor, you lose much of the picture. For some groups or conditions, poverty is not the explanation.

For example, the average black male physician dies at age 54. Infant mortality rates are higher among black women, even those that have high SES. It is not just an issue of socioeconomic status. We have good data on the Medicare population that show disparities go beyond SES.

Equally important from a policy perspective is the fact that we cannot correct social inequities quickly. We can, however, address the disparities in health care quality. We have the evidence base that says how we can do it. We must identify and use models and evidence-based practices to reduce disparities.

### **We need to address disparities within our health care financing system.**

Certain drugs that may be more effective in African American populations are not necessarily those that are reimbursed by Medicaid or Medicare.

Two of the tasks of the QIOs are to identify disparities in care within institutions and to report racial and ethnic disparities that reveal even greater gaps in quality improvement.

### **We need policymakers and coalitions of people to make change happen.**

Our government leaders must act as ambassadors for a culture of quality, to address both quality improvement and disparities. They must engage and involve the population. After all, they also belong to our communities.

The National Conference of State Legislatures held a disparities conference which included black and Hispanic legislators. They put together a list of legislative bills organized by disease and minority health status.

The National Hispanic Health Foundation has developed small Hispanic health research institutes to push forward the knowledge base and to develop education and outreach to use that knowledge effectively.

There will be no majority population in the next generation, because of changing demographics. We must address disparities now, or we will be discussing them after the fact, facing constraints such as congressional mandates.



## Panel 3—Promising National Initiatives

### Institute of Medicine

Janet M. Corrigan, Ph.D.

Senior Board Director for Health Care Services

*Structural changes within health care organizations are needed to accelerate quality improvement efforts and address disparities.*

We have made major progress in changing awareness about health care quality issues and have reached a turning point in addressing these issues.

When the Institute of Medicine (IOM) first published its report on medical errors, it met with much skepticism. We have learned since then about how to present reports to providers and communities:

- Align measures.
- Highlight priority areas.
- Give examples of population- and community-based initiatives.

#### **To improve quality, we need better organizational support structures.**

To accelerate quality improvement efforts, we need better organizational support structures, including ways to harmonize traditional professional autonomy in the medical field with new team- and evidence-based approaches. In addition, we need:

- Better technological systems to track and improve patient outcomes.
- Better supports for team-based systems of care.
- Better payment mechanisms and systems.
- Ways to address cultural resistance to change.

We can take advantage of tools that have been developed and used in other industries—for example, the engineering sector.

#### **It is critically important to look at our payment systems.**

We need to integrate population health and personal health care delivery. The highest rate of return is in population-level efforts to improve health, but our financing system puts the money in personal health care delivery.

The IOM has concluded that for systemic change, we need fundamental changes in our environment of care. It is planning the development of four new reports addressing the environmental levers of benefits design, payment policies, quality improvement, and technical assistance.

## **Robert Wood Johnson Foundation**

*Risa Lavizzo-Mourey, M.D., M.B.A.*  
*President and CEO*

*The RWJ Foundation has several initiatives to help Americans identify quality health care and to bring to light successful strategies and solutions that raise the bar on quality for minority populations.*

Zero is the only acceptable disparity. We must press further in challenging health care disparities as a key element of quality improvement.

The American public has not been brought into the discussion of disparities in a meaningful way. As defined in the Quality Challenge, we do indeed need more candor regarding quality and disparities. We need to help consumers and policymakers understand what quality, patient-centered care looks like.

### **Issues of quality and disparities must be translated into plain language.**

The Robert Wood Johnson (RWJ) Foundation is supporting a four-part television series to air on PBS called *Remaking American Medicine* to translate issues of quality and disparities into plain language and improve public understanding and discussion regarding health care in this country.

The Foundation's "We Speak Together" program is aimed at improving communications and language within health care institutions to increase quality and collaboration. For example, this program has begun to identify universal symbols to use in health care facilities to reduce language barriers.

### **RWJ's "Expecting Success" project targets solutions that reduce disparity gaps.**

The RWJ Foundation is also addressing two more of the Quality Challenge Cs—comparison and consequences—with a project called "Expecting Success." This project will investigate the best solutions in inpatient and outpatient care for reducing disparity gaps related to specific issues or conditions (e.g., cardiovascular disease or patient safety) and raising the bar on quality for minority populations.

Finally, we can take heart that many leaders and providers are taking up the Quality Challenge. There are many people of courage who are instituting changes big and small to address quality and disparities. There is increased cooperation among quality improvement organizations and others focused on reducing disparities that is creating important, positive energy.

## **American Health Quality Association**

*David G. Schulke*

*Executive Vice President*

*Quality improvement organizations are working within communities to share practical strategies for integrating quality improvement into their health care practices.*

Quality improvement organizations (QIOs) address issues of how, when, and where to start changes to address quality improvements and disparities. To address the slow rate of progress in these areas, the QIOs are learning to work more closely together to expand their efforts.

The purpose of QIOs is to offer the practical, how-to information about promoting quality improvements within health care organizations. In areas such as nursing home care and heart disease, partnerships with QIOs have seen improvements.

To improve and expand the rate of progress, quality improvement organizations are:

- Sharing strategies on what works with the Office of Minority Health.
- Integrating the importance of changing to a culture of quality into the next round of QIO designation requirements
- Working more closely and actively with their communities to develop new alliances for quality, responding to community needs. One special initiative is focused particularly around discharge policies and practices for cardiac patients.

## **Discussion**

### **We must fill in the information gaps faced by both the public and professionals.**

We cannot function on the belief that if we publish data and reports, some invisible hand will take over. The invisible hand does not know what to do. We must fill in the information gaps faced by both the public and professionals with greater networking, information sharing, and marketing.

The CDC is reorganizing two new centers to help address this gap: one devoted to health informatics and electronic health records and the other focused on health marketing. Both of these centers will address data collection and dissemination and explore how we can put channels into place to communicate more efficiently across different sectors.

### **Global changes may not address quality and disparities in diverse communities.**

Quality and disparities can vary across conditions and communities, so across-the-board changes may not be appropriate.

For example, in large urban areas such as Los Angeles, racial and ethnic definitions are too narrow to describe the wide diversity of cultures and subpopulations.

### **We need to encourage more dialog and creative ways to disseminate information.**

In the past, QIO reviews were kept closed and secret, and they were seen as working at cross-purposes with purchasers. Over time, QIOs have shifted to promoting public reporting of results and focused more attention on the need for technical assistance to share results and strategies for improving quality.

We need to encourage more dialog with purchasers and providers to address issues such as return on investments in quality improvements or how to disseminate information that is valuable to consumers.

### **Children's health care quality and disparity issues should focus on prevention.**

The topic of children and their quality and disparity issues has been absent from this discussion. Yet children are disproportionately represented among the poor.

We need to include children in the discussion, particularly in health care provider education and among professional organizations. With children, we need to emphasize a preventive approach that focuses on both public policy and behavior changes. Cigarette smoking and asthma represent examples of children's health areas where a combination of approaches produces results that are far greater than the sum of the parts.