Comparative Effectiveness: Closing the Quality Gap?

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Overall, Disparities in Health Care Are Not Getting Smaller…

- For African Americans, about 83% of report measures for health care quality have either remained unchanged or gotten worse
  - e.g. African Americans are more than 10 times likely as Whites to be diagnosed with AIDS

- 50% of measures used to track access to health care have either remained unchanged or gotten worse
  - e.g. African Americans are 25% more likely than Whites to experience communication problems with their providers

AHRQ 2007 National Healthcare Disparities Report
Concerns about health spending – about $2.3 trillion per year in the U.S. and growing

Large variations in clinical care

A lot of uncertainty about best practices involving new treatments and technologies

Pervasive problems with the quality of care that people receive

Translating scientific advances into relevant, usable information for health care professionals and patients
Comparative effectiveness research serves as a foundation for evidence on what services work best in health care.

- Comparisons of medical options help clinicians and patients make individualized treatment decisions.
- The information base on what services improve quality, safety and effectiveness is enhanced.
- Consumers play important roles in developing and using the information as citizens, community members, participants in policy deliberations and as patients.
Comparative Effectiveness: Closing the Quality Gap?

- Comparative Effectiveness and the American Recovery Reinvestment Act of 2009 (ARRA)
- AHRQ’s Role in Comparative Effectiveness
- Comparative Effectiveness Research: The Future
- Q&A
AHRQ Priorities

- **Patient Safety**
  - Health IT
  - Patient Safety Organizations
  - New Patient Safety Grants

- **Effective Health Care Program**
  - Comparative Effectiveness Reviews
  - Comparative Effectiveness Research
  - Clear Findings for Multiple Audiences

- **Ambulatory Patient Safety**
  - Safety & Quality Measures, Drug Management and Patient-Centered Care
  - Patient Safety Improvement Corps

- **Medical Expenditure Panel Surveys**
  - Visit-Level Information on Medical Expenditures
  - Annual Quality & Disparities Reports

- **Other Research & Dissemination Activities**
  - Quality & Cost-Effectiveness, e.g. Prevention and Pharmaceutical Outcomes
  - U.S. Preventive Services Task Force
  - MRSA/HAI
AHRQ FY 2009 Funding

- $372 million
  - $37 million more than FY 2008
  - $46 million more than the president’s request

- FY 2009 appropriation includes:
  - $50 million for comparative effectiveness research, $20 million more than FY 2008
  - $49 million for patient safety activities
  - $45 million for health IT
The American Recovery and Reinvestment Act of 2009 includes $1.1 billion for comparative effectiveness research:

- AHRQ: $300 million
- NIH: $400 million (appropriated to AHRQ and transferred to NIH)
- Office of the Secretary: $400 million (allocated at the Secretary’s discretion)

Funding for health IT, prevention and other areas could have implications for the Agency
Recovery Act Timeline: AHRQ

February 17: The American Recovery and Reinvestment Act of 2009 is signed into law

March 19: Establishment of Federal Coordinating Council for Comparative Effectiveness Research

April

May 1: Due date for Agency wide and program-specific Recovery Act plans

June 30: Due date for IOM submission of a list of national priority conditions*

July

July 30: AHRQ to submit FY ’09 Operations Plan

October

November 1: AHRQ FY ’10 operations plan due

December 31, 2010: All Recovery Act funding to be obligated

* Stakeholder input required
Federal Coordinating Council

- Anne Haddix, CDC
- Thomas Valuck, CMS
- Peter Delany, SAMHSA
- Carolyn Clancy, AHRQ
- Deborah Hopson, HRSA
- David Hunt, ONC
- James Scanlon, HHS
- Garth Graham, Office of Minority Health
- Elizabeth Nabel, NIH
- Jesse Goodman, FDA
- Michael Marge, Office on Disability
- Neera Tanden, HHS
- Joel Kupersmith, VA
- Michael Kilpatrick, DoD
- Ezekiel Emanuel, OMB

Federal Coordinating Council
Listening Sessions to Be Announced
Other Aspects of the Recovery Act

- Comparative Effectiveness Research conducted with funds appropriated under the Recovery Act, “shall be consistent with Departmental policies relating to the inclusion of women and minorities.”

- Congress does not intend for the research money to be used to “mandate coverage reimbursement or other policies for any public or private payer.”

- Details about the types of research being funded or supported must be submitted to Congress every six months, beginning Nov. 1, 2009

www.hhs.gov/recovery
A. Evidence synthesis (EPC program)
   - Systematically reviewing, synthesizing, comparing existing evidence on treatment effectiveness
   - Identifying relevant knowledge gaps

B. Evidence generation (DEcIDE, CERTs)
   - Development of new scientific knowledge to address knowledge gaps.
   - Accelerate practical studies

C. Evidence communication/translation (Eisenberg Center)
   - Translate evidence into improvements
   - Communication of scientific information in plain language to policymakers, patients, and providers
Broad opportunities for input at [www.effectivehealthcare.ahrq.gov](http://www.effectivehealthcare.ahrq.gov)

- Priority setting
- Specific questions to be evaluated**
- Comment on draft reports
- YOUR suggestions?
New Resources – New Opportunities!

- Expanded infrastructure and capacity for Comparative Effectiveness Research
- Prospective studies that include under-represented populations
- Pushing forward on methods for Comparative Effectiveness Research (June 1-2 Symposium)
- Increasing investments in innovative broad dissemination and translation
The Future

- Public-private funding and participation likely a necessity
- More effort to get better conditional reimbursement study designs/protocols
- Patients should be engaged as partners at the local and national levels
- Need to tackle important issues
  - Ethical
  - When to know when the evidence is sufficient
  - Transparency
  - Setting priorities
Moving Forward: Issues to Consider

- Comparative Effectiveness is a useful tool in a much larger toolkit – it is necessary but not sufficient.
- It does **not** make policy or health care decisions, tell doctors how to practice medicine or make final decisions about what kind of treatments insurers will pay for.
- It does weigh the evidence and present it in a way that helps consumers and their doctors make the best possible decisions about health care choices.
- It’s also an opportunity to identify what is not known/areas where research is needed.
2009 AHRQ Annual Conference

“Research to Reform: Achieving Health System Change”

September 13-16, 2009
Bethesda North Marriott Convention Center
Bethesda, MD

Sessions on topics including the following:
- Increased Funding for Comparative Effectiveness
- AHRQ’s Rapidly Expanding Health IT Portfolio
- Implementation of Research Findings into Changes in Practice and Policy

MARK YOUR CALENDARS!
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- AHRQ’s Role in Comparative Effectiveness
- Comparative Effectiveness Research and IT: The Future?
- Q&A