



## **NEW REPORTS SHOW FEW IMPROVEMENTS IN HEALTHCARE QUALITY**

The Agency for Healthcare Research and Quality (AHRQ) finds our healthcare system rife with inconsistencies and disparities in its latest quality reports. The National Healthcare Quality Report, compiled in 2004 and released in February 2005, focuses on gaps in quality across the healthcare system, while the 2004 National Healthcare Disparities Report narrows its focus to disparities in healthcare quality for minority populations. Though both reports highlight promising trends, the data show that gaps in quality and in access to the healthcare system persist, demonstrating the need to continue to expand quality improvement initiatives that promote long-term change.

Poor quality care affects everyone, but as the reports confirm, low-income seniors and seniors who are members of minority groups are more likely than younger populations and non-minorities to experience poor quality care. The Disparities Report also confirms that an increasing number of seniors have low-incomes and belong to minority groups. While 17 percent of seniors belonged to a minority group in 2000, that number is expected to grow to over a quarter of the total senior population by 2030. Concomitantly, according to the Medicare Payment Advisory Committee (MedPAC) June 2003 and 2004 Data Books, 17 percent of Medicare beneficiaries had incomes below the federal poverty level in 2001, up from 16 percent in 2000. As low-income and minority seniors represent a growing percentage of the elderly population, it is particularly important for advocates to understand how poor quality care and healthcare disparities further complicate the myriad problems already facing these vulnerable populations.

### **2004 National Healthcare Quality Report**

The 2004 National Healthcare Quality Report largely echoes conclusions drawn in the 2003 report: quality improvement takes time, gaps in quality persist, and improvement is possible. The report is based on 98 measures for which time-trend data are available, with the most recent data dating to 2002. In 2004, 67 of these measures showed improvement, though only 25 improved more than 5% compared to reports published in 2003. Data for half of the measures show little to no change (between -5% and 5%).

The quality measures used in this report measure both processes (were the correct clinical procedures followed) and outcomes (did the patient achieve the desired recovery), and rely on scientific data as well as patient feedback. Measures are grouped into four overarching areas of quality:

- **Effectiveness** measures, which comprise the bulk of the survey, include screening rates (process) and death rates (outcome) for several cancers, diabetes, kidney disease, heart disease, HIV/AIDS, mental health, respiratory diseases, and nursing home care.
- **Patient safety** measures report on quality indicators such as hospital acquired infection rates, adverse events after operation, and inappropriate use of medications by the elderly.
- **Timeliness** measures document “the ability to receive care when needed.” Measures range from patient perceptions of getting care when they needed it, to actual time gaps in receiving the appropriate treatment after various health episodes such as heart attacks and pneumonia.
- **Patient centeredness** measures rely entirely on patient perceptions of the quality of care received. Measures documented, for example, whether doctor instructions were clear and whether patients felt respected by their doctors.

As in earlier reports, it is noted that quality varies greatly among geographic areas and among different measures. Some measures showed significant improvement, such as relative decrease of 34% in elderly patients who receive potentially inappropriate medications, while other measures show significant decline, such as the 20% decrease in elderly pneumonia patients who received their first dose of antibiotics as recommended by clinical guidelines.

The report emphasizes the need to continue developing and refining quality measurement tools in an effort to accurately chart quality trends in the United States. The 2003 report will serve as a baseline for subsequent reports by which improvement can be measured. The full report, including data sources and methodology, is available at <http://www.qualitytools.ahrq.gov/>.

## **2004 National Healthcare Disparities Report**

The 2004 National Healthcare Disparities Report documents for the second year in a row pervasive disparities in access to and the quality of healthcare for minorities in nearly all areas of care. According to data gathered in 2000 and 2001, the report shows an overall increase in the percent of measures for which minority groups experience poorer quality care compared to whites, though disparities for particular measures improved. The report draws three major conclusions from the data: “disparities are pervasive, improvement is possible, and gaps in information exist, especially for specific conditions and populations.”

The report is based on 38 measures of care and 31 measures of access, though data on all measures are not available across all races and ethnicities. The data revealed the following:

- Quality of care for blacks decreased, with data showing disparities for nearly two-thirds of quality measures, the highest of any group. Blacks had poorer access to the healthcare system for 40 % of the measures.
- Healthcare quality sharply decreased for Asians; they received poorer quality care for 10% of the measures, down from less than 5% in 2000 (with data available for 24 measures). Disparities in access to care for Asians hovered at one-third of the 26 measures for which data were available.

- Quality also decreased for American Indians and Alaska Natives. They received poorer quality care than whites for one-third out of 21 quality measures for which data were available, and for one-half of the 16 access measures for which data were available.
- Disparities in quality and access are especially persistent for Hispanics and for the poor. Disparities were reported for one-half and 60% of quality measures, respectively. Access disparities were even greater, with Hispanics showing worse access to healthcare for 90% of measures, poor people for 80%, when compared with whites. Access for both groups decreased from 2000 to 2001.

Though progress is not evident in the aggregate data, minority health disparities improved in some areas, especially when quality initiatives to reduce disparities were sponsored by the Department of Health and Human Services. No disparities were documented for the management of anemia in patients with end-stage renal disease; the report notes that this coincided with the Center for Medicare and Medicaid Services End Stage Renal Disease Clinical Performance Measures Project. Other similar reductions in disparities occurred for Pap testing for black women, which coincided with the Center for Disease Control's National Breast and Cervical Cancer Early detection Program, and for blood pressure monitoring for blacks, which coincided with the National Heart, Lung, and Blood Institute National High Blood Pressure Education Program.

The report also focused on select priority populations, including low-income groups and the elderly, populations mostly served by Medicare, Medicaid, or both.

- **Low-income** groups often experience worse health and lower quality care than higher income groups. This is true even when factors such as lack of health insurance are taken into consideration. Low-income populations also experience significant barriers in accessing the healthcare system, including a lack of insurance and difficulty obtaining referrals to specialists. The report notes that federally supported community health centers, which disproportionately serve low-income areas, significantly reduce quality and access disparities by providing care in geographic areas where access is often limited. They are an important resource for those who fall through the safety net provided by public programs such as Medicaid.
- **Elderly** populations still experience health disparities due to race and income, despite the success of Medicare coverage. Low-income seniors with Medicare experience health disparities across the board, disparities which are even more pronounced among low-income blacks, Asians and Hispanics. Minorities and low-income seniors report disparities in areas such as cancer screening rates, vaccinations, and having a usual source of care. They also report greater difficulties than whites in gaining access without delay to needed care. Over 15% of seniors were living below 125% of the federal poverty level in 2002.

The full report, including data sources and methodology, is available at <http://www.qualitytools.ahrq.gov/>.

Despite encouraging results in some areas, the aggregate data from these reports point to a persistent quality chasm. The Center for Medicare Advocacy, Inc. continues to advocate for increased awareness of disparities in healthcare quality and access through a variety of methods, including data collection and quality reporting.

The 2004 National Healthcare Quality Report and the 2004 National Healthcare Disparities Report are published annually by the Agency for Healthcare Research and Quality (AHRQ), an agency within the Department of Health and Human Services.