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In Conversation with…Carolyn Clancy, MD

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Editor's Note: *Dr. Carolyn Clancy has been the Director of the Agency for Healthcare Research and Quality (AHRQ) since 2003. Prior to becoming AHRQ Director, she led the Agency's Center for Outcomes and Effectiveness Research. A general internist and health services researcher, she has published widely in the peer reviewed literature on a variety of topics, ranging from quality improvement to primary care. She is a member of the Institute of Medicine and a Master of the American College of Physicians.*

Dr. Robert Wachter, Editor, AHRQ WebM&M: How do you think the nation is doing in patient safety 5 years after the IOM Report?

Dr. Carolyn Clancy: I think we're doing very well in some areas, and in other areas we could be doing a lot better. Specifically, I believe we've made impressive advances in creating awareness that patient safety is a problem. The IOM Report galvanized a lot of public concern and attention, and it galvanized clinicians and health care organizations as well. I would also point to the medical specialty boards, which are now beginning to incorporate efforts in improving patient safety as a part of maintenance of certification. These efforts suggest that safety is slowly seeping into the actual settings of care and the education of providers. That's all really good news. What is less good is that it is actually impossible to answer the question "Is the health care system any safer now than it was five years ago?"

RW: How important do you think it is to answer that question? If it's important, how would you go about doing that?

CC: We have debated within AHRQ about whether it would be worthwhile to try to repeat the studies that led to the estimates of 44,000-98,000 deaths per year from medical errors, but we've concluded that we really need to focus on improvement. We have many dramatic examples of successes that have resulted from our investments in research, such as reducing ventilator-associated pneumonia in some hospitals to near zero. What has impressed me is that other institutions are contacting Peter Pronovost [who has done much of the pioneering research on this, often with AHRQ support] to say they want to be part of this effort, too. Also, the very enthusiastic response to the 100,000 Lives Campaign indicates that we're ready to act in a way that we might not have been 5 years ago. Having said that, of course, any effort to improve reporting of medical errors will have to address the obvious barriers—most importantly, the fear of sanctions and

liability.

RW: What do you think is AHRQ's most important contribution over the last 5 years?

CC: There are several contributions I would point to with great pride. One is building the evidence base about patient safety in settings beyond the hospital. The numbers and the information about what happens in hospitals are certainly sobering enough, but until recently we hadn't even looked at ambulatory care, nursing homes, or other settings. We have a lot of exciting work in progress right now. A second great area is health information technology [HIT] to improve patient safety. A third area would be AHRQ's Hospital Survey on Patient Safety Culture—more and more organizations are coming to us and saying, "Can we really use this for free?" I think those are all critically important.

RW: What do you see as AHRQ's unique role with respect to information technology?

CC: AHRQ sits uniquely at the intersection of health information technology and patient safety, asking how HIT can be applied in real-world clinical settings to make health care safer. Now, on some level, there's been so much excitement about the potential of HIT that its value may seem almost self-evident. People think, "Of course, if you install a clinical information system, you will have safer health care," and yet, we're seeing that is not necessarily the case. Some very promising studies have been done and more are in the pipeline, but what everyone is beginning to understand is that HIT's successes are rarely "out of the box." It's not yet "plug-and-play." It's probably one part technology and two parts culture and workflow change. And that's precisely where we are focusing our investments. Moreover, many providers don't necessarily have safety and quality at the top of their lists of reasons to invest in HIT. They're also thinking about things like efficiency and risk management. The investments that we're making, building the evidence base to show how selected applications of HIT can improve quality and safety, are going to go a long way.

RW: How do you think the Agency comes down between the purist view of evidence-based medicine and a perhaps more practical or business-oriented view; namely, that some changes need to be made based on imperfect evidence or even just common sense?

CC: We recognize that in some instances we need to think more creatively about how to move from the purist view to one that recognizes that, in some cases, the strength of the evidence is less than you would like but action is still needed. We don't just struggle with this in patient safety, we struggle with it on the U.S. Preventive Services Task Force, which often must make recommendations in the face of insufficient evidence. I see this as a very dynamic issue for the entire field of evidence-based practice. At the same time, it's very easy to be glib and say, this practice has so much face validity that we should just do it, even in the absence of meaningful evidence. Health care is such a complex undertaking that even commonsensical practices can do harm—or drain resources but provide no benefit—and require some sort of evaluation. That's the tension that we are trying to reconcile.

RW: It strikes me that AHRQ lives in a slightly more tenuous position regarding its funding and perhaps even its mission and focus than traditional organ-based NIH agencies. First of all, do you think that's true; and second, how does that influence what the Agency does and how the Agency chooses its agenda?

CC: I think that it is true; partly because this country places a very high value on discovery. If we discover something brand new, the expectation is that the discovery will be perfectly applied to practice fairly rapidly. Over the past several years, it's becoming increasingly clear to the public and to members of Congress that discovery is great but that expectation may be a bit misplaced, particularly since the delivery system is so stressed. How this influences our work, I think, is both positive and a little bit negative. It's hard in a tenuous funding environment not to occasionally be a bit risk-averse. That's the downside. The upside is, since we don't enjoy this sense that the budget will just grow bigger every year, it inspires a sense of creativity and innovation, and an understanding that we have to communicate very clearly to multiple audiences why the work we're doing is so important and what the role of research is.

RW: How does that need manifest itself in your day-to-day work?

CC: I think that communicating and focusing on the use of evidence to improve practice is hard-wired into the Agency's mission. Our mission statement no longer says that we're a research agency and we conduct important research that will *hopefully* lead to improvements. Now it says that our mission is to improve the quality, efficiency, and effectiveness of health care. That has had a very positive impact across the organization. A couple of other recent external influences are forcing us to think more creatively about how we communicate our results. The first is that more and more consumers are seeing and understanding that they have a vital role to play as partners in health care. The second is that health care inflation and its impact on individuals, with more out-of-pocket expenses, is making some people into activists, even if that isn't in their usual nature. They now ask, "Gee, if this service is costing me this much, do I really need it?" It inspires a lot of questions that were not asked before.

RW: AHRQ is a bit unique in that it frequently finds itself in the middle of issues that have important political dimensions: things like pay-for-performance, malpractice, quality measurement, and patient safety legislation. How do you position the Agency in terms of taking a neutral arbiter role versus an advocacy role?

CC: In some areas, people do have very strong feelings. Many physicians, for example, have very strong views about various aspects of malpractice reform. In general, we've tried to position the Agency as a science partner to agencies such as CMS [Centers for Medicare and Medicaid Services] that have to make the tough operational calls and policy decisions. Having said that, we've also learned that taking a ‘just the facts' approach still means that you have to present information in ways that are understandable to and actionable by the policy makers. It's a fine line to walk, but it's a very exciting one.

RW: From where you sit now, thinking back on how you were trained in medical school, what do you think the fundamental changes in the way we train doctors, and maybe all health care professionals, are going to be, and what will be the Agency's role in making these changes happen?

CC: I guess when I was trained as a student and resident, the culture of medicine was such that doctors were in charge. Over the past 15 or 20 years, many more questions are being asked by a variety of stakeholders—particularly purchasers, but consumers as well. I don't believe that today's clinical training teaches people how to deal with this effectively. There are some huge opportunities there. On the other hand, I think awareness of errors and the potential to do harm is now being made a part of clinical training.

However, the role of physicians in creating better systems and how they work with others in effective teams is still underemphasized, if it's mentioned at all.

RW: One of the things that has been striking to me in examining the aviation analogy is that a lot of things are different between aviation and health care—not only is the initial certification different, but the role of recertification over the course of a career is very different, with pilots needing to frequently demonstrate their ongoing competence. Do you think we're just seeing the beginning of a much more vigorous lifelong scrutiny of practice patterns and quality for physicians? If so, is there a unique role the Agency might have in this arena?

CC: Clearly, I think we are very much at the beginning. Right now, some Americans have not heard about health care report cards. But more are learning that there's more information about quality out there, and I think that is likely to feed on itself in sort of a positive reinforcing cycle. You get some information, for example, about aspects of hospital care and you want to know more, and you want to know why you don't know this about individual doctors, and so forth. To me, this underscores that there's going to be more and more transparency in health care, and I think that's a good thing. The question will be whether this transparency inspires learning and excitement among providers, or whether it feels like being trailed by accountants who check up on you and report when you do things badly. That tends to be far less exciting than the idea of learning new things.

RW: How will the Agency focus its energy in terms of promoting transparency?

CC: In the near term, we are going to need to aim for what people call a balanced scorecard approach, where you use a mix of both process and outcome measures such as those found in AHRQ's National Healthcare Quality Report. In the longer term, we need to be sure that our measures are salient to individual consumers. The question is, as we get smarter about the processes and systems in organizations, will we be able to identify a parsimonious list of measures that predict an institution's performance on both key processes and meaningful outcomes? Ultimately, the people providing care also need that information to know what to fix and where to take action. But I'm not sure that that's the same information that the public and other decision-makers are interested in.

RW: For my last question, I wanted to give you a chance to say something about Dan Stryer [the Director of AHRQ's Center for Quality Improvement and Patient Safety, who died at age 41 in May 2005] and his contributions to the Agency.

CC: Dan inspired us all to be better people in so many ways. He came to the Agency in 1997 and was unfailingly upbeat and optimistic. He did not shy away from tough questions when he thought about eliminating disparities in health care and improving health care quality and safety. Notwithstanding any challenges on a day-to-day level about where the health care system stood, he was very much like John Eisenberg [the late AHRQ Director, who also died at a young age in March 2002] in that he always managed to see the glass as half full. He also was an inspiration because he had a very strong sense of balance in his life. We all knew how much we loved him, but, at his memorial service, it was really, really wonderful to see hundreds of people whom I had never met who loved him that much, too.