PSNet
PATIENT SAFETY NETWORK

In Conversation With… Richard Kronick, PhD

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Editor's note: *Dr. Kronick has served as director of the Agency for Healthcare Research and Quality since August 2013 and will be stepping down from the role this month. He has conducted and coordinated research on policies relating to public health, health care delivery, health insurance, and health care financing programs. We spoke with him about AHRQ's efforts to develop measurements and implement improvements in patient safety.*

Dr. Robert M. Wachter: Tell us what you see the largest issues in safety are in which AHRQ can make a difference.

Dr. Richard Kronick: AHRQ has been a leader in the patient safety movement since its inception. It's been nearly 15 years since the IOM's initial report on patient safety galvanized the movement. We have made substantial progress, as evidenced by the remarkable improvement in hospital safety over the past few years. As shown in a recent AHRQ report, in 2010 there were 145 adverse events for every 1000 hospitalizations; in 2014 that rate decreased to 121/1000. As a result of this 17% improvement in safety, there were 2.1 million fewer adverse events over the 2010 to 2014 period than would have occurred if the 2010 rate had remained unchanged, and, more importantly, 87,000 fewer deaths and close to $20 billion in cost savings. However, health care is not nearly as safe as it should be or can be. The rate of 121 adverse events per 1000 hospitalizations still represents substantial harm to patients caused by the delivery of care, and we are in the early stages of figuring out how to improve safety in nonhospital settings—particularly ambulatory and long-term care. Key challenges include developing evidence about how health care can be made safer, working with our partners inside and outside of government to make sure that providers and patients really understand that evidence, and working to create an environment in which there are incentives to overcoming barriers to implementing the evidence.

Much of our work has focused on improving safety in the hospital, but outside the hospital there are many challenges as well. So we're working on accelerating patient safety improvement in nursing homes and in ambulatory care—particularly focusing on advancing our understanding of diagnostic safety. We have made extensive progress in changing the culture in hospitals and other health care institutions and in reducing adverse events. There has been a lot of work and some really significant signs of progress, and there is a tremendous need for more work and many challenges to overcome in the future.

RW: What research has AHRQ done in measuring quality and disparities? For example, part of the challenge is how do you measure diagnostic errors? The measurement challenge becomes an obstacle as you try to figure out how to understand the scope of the problem and how to improve it.

RK: AHRQ publishes an annual report that describes many measures of quality, safety, and disparities. It is very valuable at the national level, and many of these measures drill down to the state or local level so that it becomes more actionable. The 2014 report showed progress in a variety of areas—most notably access to care. Recent estimates are around 20 million fewer people uninsured than just a few years ago. It also showed improvements in quality on a number of measures publicly reported by CMS. At the same time, the report shows that, across a broad array of measures, only about 70% of recommended care is delivered, and on some measures even less: for example, barely more than 50% of people with high blood pressure have it under control. And the report shows that there has been very little progress in reducing disparities, although the disparities data in the report did not include the effects of the 2014 coverage expansion. There's clearly still a lot of work to do.

As noted in the recent IOM report, we don't yet have good measures of diagnostic accuracy. In 2015, we released a Funding Opportunity Announcement describing our interest in funding grants that will make progress in reducing diagnostic errors, and part of our interest is in funding work that will develop better measures of diagnostic accuracy. We look forward to funding work that will make progress in meeting this challenge.

RW: In terms of individual measures, everybody's a little whipsawed these days. You hear people say, "We need more and better measures," and you also hear about measurement fatigue—"There are too many measures." How do you navigate that?

RK: CMS and private payers have recently made substantial progress by reaching agreement on a core set of measures to use when assessing physician performance. Full implementation of this agreement, which will take a few years, will make progress on the "too many measures" problem. However, CMS and private payers were necessarily limited to choosing core measures from among the measures that have been developed and validated, and it is clear that we do not have valid measures for many of the most important features of high quality medical care. For example, we don't yet have good measures of diagnostic acumen, or of the quality of a physician's advice about the benefits and harms of treatment options, or about the extent to which patients and families are meaningfully engaged in the decision-making process. In some of these areas, developing useful measures may be possible. We need further work to develop better measures, as well as to better understand inherent limits in our ability to measure much of what matters in medical care.

RW: Patient and family engagement has been a priority area for AHRQ. What are you doing in that area, and what resources have you developed?

RK: Patient and family engagement is crucial to improving quality and safety. AHRQ research, as well as what's been sponsored elsewhere, has demonstrated that quite strongly. To promote greater engagement, AHRQ has developed a guide to help patients, families, and health professionals work together as partners. *The Guide to Patient and Family Engagement in Hospital Quality and Safety* focuses on four primary strategies for promoting patient and family engagement in hospital safety. First, encouraging patients and family members to participate as advisors. Second, promoting better communication among patients, family members, and health care professionals starting from the point of hospital admission and continuing throughout the stay. Third, enhancing continuity of care by keeping the patient and family informed through nurse bedside change-of-shift reports, assuring that during shift changes it is not simply one nurse talking with another, but also involving the patient and family. Fourth, engaging patients and families in discharge planning throughout the hospital stay. This guide is a very good example of how our programs identify opportunities to help others understand scientific evidence and how to use it. This particular resource is focused on inpatient hospital care. We are working on developing similar resources for ambulatory care.

RW: Talk about some of the resources AHRQ has developed in patient safety.

RK: One of AHRQ's priorities is patient safety, and we are a leader in developing tools and resources to improve health care quality and safety. Let me name a few of them. The Comprehensive Unit-based Safety Program, or CUSP, toolkit includes training tools to make care safer by improving the foundation of how physicians, nurses, and other clinical team members work together. It builds the capacity to address safety issues by combining clinical best practices with the science of safety to ensure that evidence-based care is delivered. This tool has been used widely throughout the nation. A second tool, the Team Strategies and Tools to Enhance Performance in Patient Safety, or TeamSTEPPs, is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a customizable training curriculum to successfully integrate teamwork principles into health care systems. We've trained many thousands of master trainers, who in turn train hundreds of thousands of health care workers in these communication tools and TeamSTEPPs. A third tool is the Re-Engineered Discharge toolkit, or RED, which was designed to help hospitals reengineer and improve their discharge process. The study modules and supporting materials will help hospitals become familiar with RED's process and components, determine metrics for evaluating impact, and learn how to implement RED.

We have been working on developing a medical liability improvement toolkit titled, Communication and Optimal Resolution, or CANDOR. The objective is to create a toolkit to assist hospitals in implementing a communication resolution program. Key elements of these programs include full disclosure of an adverse event, apology, and then fair and rapid compensation. These efforts are intended to reduce the risk of harm, improve patient?provider communication, and reduce the likelihood of litigation. We've seen remarkable success with these kinds of early disclosure communication and resolution programs. It has been challenging to take the success in institutions where there is a charismatic leader and real strong supporter for these programs and implement them more widely. And we're working on developing a toolkit to help implement them more widely.

RW: As you reviewed those tools it struck me there was a theme in many of them—that they had initially been developed, often with AHRQ's support, at a single institution and with a visible leader. Peter Pronovost comes to mind for CUSP, and Rick Boothman at Michigan for the liability one. How do you decide that a certain tool is ready for scaling? Maybe it worked so well in a given environment because of the single champion who was charismatic and sold it, but now you're trying to scale it across 50 states.

RK: It's a really good question. AHRQ is an evidence-producing agency; it's fundamental to what we do. We then try to make sure that the evidence is understood and used. We try to make evidence-based decisions on whether and when tools are ready for scaling. We do research to figure out what happens if we take this tool and try to implement it at many more institutions. Was it implemented successfully? Did we see the outcomes that we expected to see? And if not, then we make changes to the tool if that is what's needed to try achieve the desired outcomes. When we have evidence that suggests something works, then we work at broader scale implementation.

In the case of CUSP for central line infections, we had substantial resources to actually do quite a bit of that broader implementation ourselves, but in many instances, we are working within HHS, particularly with CMS, on broader scale implementation. So in the case of the patient and family engagement toolkit—where we again had some evidence that it actually was useful and worked—it was the Hospital Engagement Networks, which CMS funds as part of Partnership for Patients, that used that toolkit much more broadly. We have seen substantial progress in patient and family engagement in hospitals across the country.

As you note, one key problem in safety and quality is always figuring out whether an intervention that works in a couple of places can really be brought to scale and how to do that successfully.

RW: AHRQ has gotten into health IT in a major way over the last 5 or 6 years. What do you think you've accomplished? What are some of the unique challenges that you've confronted?

RK: Our goal is to develop and disseminate evidence to inform policy and practice related to how health IT can improve the quality of health care. We work on trying to figure out how health IT can be used to improve quality and how we can make sure that health IT is used safely. Our research is focusing on how health IT can be designed and used to improve care, particularly looking at workflow—how clinical decision support systems can be best used to inform decisions at the point of care. We have done seminal work on barcoded medication administration and computerized provider order entry. The work we did there established the body of evidence showing that these technologies can improve patient safety. We put the resources Congress gives us—approximately $22 million this fiscal year—into research and the development of evidence. But this research is clearly a small part of an enormous industry, with annual revenues in the neighborhood of $40 billion. It is challenging to develop evidence that will be useful in actually leading to improvements in how health IT is used. I think we have been successful in that challenge, but it is an ongoing and constant part of the environment.

RW: Talk about the political environment that you find yourself in. You're a political scientist by career. You're at a moderate-sized agency with considerable impact, but a lot of the work you do has to be mediated through or certainly influenced by other federal organizations and then foundations, delivery systems, IT vendors, and others. How do you navigate that?

RK: Carefully. Our mission statement is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. That second phrase is a really important part of the mission statement. It's to remind everybody who works here that the production of evidence in and of itself doesn't do anything. We have to be working with partners to make sure that that evidence is understood and used. As you said in the question we're a moderate-sized agency, about 300 people, a $430 million budget for FY 2016—not as much as we would want, although not an inconsequential amount either—but a teeny part of a $3 trillion health care system with 800,000 physicians and 5,000 plus hospitals. We must constantly pay attention to partnerships and try to ensure that the evidence is understood and used. We have a tremendous leg up in that in that we are part of a department that's purchasing more than a trillion dollars' worth of health care. We have colleagues who look to us for the production of evidence. For example, efforts such as the Partnership for Patients Program are dependent on the evidence that we produce. We are constantly focusing on how to make sure that what we do changes policy and practice. To do that, we must work with our partners both inside and outside of government at every turn.

RW: Given that second part of your charge, the one that involves trying to identify what works and then be sure it's implemented, you must hit political walls. Some interest groups have vested interests in doing more of *x* or less of *y*. Sometimes the evidence supports that, and sometimes it doesn't. How do you navigate those waters?

RK: We need to be cognizant of barriers to implementation and to adoption of evidence, and we need to try to figure out how to overcome those barriers. In any environment (whether political or corporate) that has its own politics, you always need to consider the obstacles to accomplishing the goals of the organization and how to overcome those obstacles.

RW: Some people will say there's been no progress in safety and still quote a *New England Journal of Medicine* paper from 2010 showing no improvements in North Carolina hospitals. Is that just a compelling and easy to understand story? What's the obstacle to getting the good news out?

RK: There's a lot of information in the environment. The report we released in 2015 showing that hospital care has become much safer and that 87,000 fewer people died as a result, did receive very good coverage in all the major media, as did a similar report that we issued in 2014. President Obama cited the 2014 report in the rollout of the Learning in Action Network that was part of the Administration's delivery system reform effort. After he cited it, the fact checker from the *Washington Post* did quite a lot of digging to try to see where this number came from and whether it was right number. After quite a bit of digging, Glenn Kessler—who looks at what politicians say and rates them typically as "3 Pinocchios," "2 Pinocchios," or "1 Pinocchio"—gave this claim what he called the "elusive Gepetto checkmark." However, it is still the case that few people are aware of this remarkable result—I often ask audiences at talks I give whether they know that hospital care was much safer in 2014 than in 2010 and that 87,000 fewer people died as a result of the improvement in safety. Typically only a smattering of audience members will raise their hands. We need to work harder and smarter in communicating this information.

RW: As you prepare to leave AHRQ, what is your vision for the future of health services research?

RK: We will continue to support research that identifies the most effective ways to improve safety with a much more rapid cycle going from ideas to evidence to implementation. We've been making great progress. There is always frustration at the length of time, and we'll be working on trying to reduce that cycle time. Beyond safety, we'll be doing work on trying to support the efforts to figure out how to purchase health care more effectively. The mantra is that we want to pay for value, and we're making progress in trying to figure out how to do that. But there are also tremendous challenges in figuring out how to do that, and particularly figuring out how to construct incentive systems that catalyze providers' intrinsic motivations for improvement as opposed to becoming check-box exercises that have the danger of crowding out the intrinsic motivations for improvement.

RW: Do you see the EHR as a fundamental enabler of improving cycle time? We always hoped that once we had computers and could embed practices in them that it wouldn't be 7 years between an article and a change in practice, but that you could make that happen more quickly. I think most people are a little disappointed so far. Do you think that will eventually work out?

RK: I think it will. It will take concerted effort from the research side, the certification side, and in the development and vendor community to make that happen. There is a sort of natural impatience. I'm reminded of the introduction of the sewing machine: I'm told that when sewing machines were introduced, both workers and owners thought it didn't fit into their workflow, and it reduced productivity for a while. It does make sense that change would take some time. There is potential for improving the information available to clinicians and to patients and for having clinical decision support tools to deal with some of the tremendous uncertainty that providers and patients constantly face. The potential is clearly there, and I'm sure we'll be working on getting from the potential to actuality for many years.