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HEALTH POLICY

ADVOCATING FOR HEALTH SERVICES RESEARCH AND AHRQ

Thomas Kingsley, MD, MPH

Dr. Kingsley (Kingsley.Thomas@mayo.edu) is a senior associate consultant and instructor of medicine at Mayo Clinic.

In 2000, the Institute of Medicine (IOM) released "To Err Is Human," a report that awoke the medical community and the public to a startling reality: health care too often harms. Eighteen years after this landmark report, there has been evidence of improvement, but one troubling reality remains—we still harm too many patients. This fact is unavoidable. Medical errors continue to be one of the leading causes of death in the United States. A Johns Hopkins study found that medical errors killed 250,000 people in 2013, making it the *third* leading cause of death behind heart disease and cancer.[1] Although the study's methods may have led to overestimates of the number of deaths caused by medical errors, the estimates are nevertheless alarming. Another startling example of health care's harm is the opioid epidemic. For decades, physicians uninhibitedly prescribed opioids to their patients with pain. Not too long ago, I was sitting in a medical school lecture given by a renowned professor who explained to a group of attentive medical students that opioids were "not that addictive" and "pain should never go untreated." Unfortunately, this professor as well as most of the medical community got this wrong. Today, towns throughout the United States are being crippled by the opioid crisis that kills more than 100 lives every day.[2]

Thus, we arrive at the following question asked after "To Err Is Human" was published—how do we improve our healthcare system so that it does not harm those it intends to heal? An answer to this question will take further investment in health services research; researching how we deliver care, its quality and safety, and evaluating the impact of newly implemented value-based methods.

To the public, *health services research* is an obscure term, but to many clinicians, researchers, and policy makers, it is an essential part of improving our healthcare system. The Agency for Healthcare Research and Quality (AHRQ) funds a large portion of the health services research in the United States. The importance of the agency's work is evident. Since 2010 AHRQ-funded research is estimated to have decreased hospital acquired conditions by 21%, prevented 3 million adverse events, and saved 125,000 lives.[3]

AHRQ has also created the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, the Healthcare Cost and Utilization Project (HCUP) databases, and the Medical Expenditure Panel Survey (MEPS). These publicly available datasets have been invaluable to our understanding of patients' experiences with care and the delivery and costs of care in the United States and the effects of various health policies on care and outcomes. Primary care research, often underfunded compared with research focused on specialty care, has been another beneficiary of AHRQ. For example, EvidenceNow is a $112-million-dollar project to fund 1,500 primary care clinics to implement cardiovascular evidence-based care and study how this impacts outcomes.[4]

It may come as a surprise then that AHRQ's future has been precarious. Proposals for eliminating AHRQ have been brought forth in Congress several times in the recent past. None have succeeded, yet. In February 2018, the President's FY19 budget proposal was released to Congress, and it recommended a major funding cut to AHRQ from $322 million to $256 million, an approximately 20% decrease from FY18 (see figure on page 2).[5] Beyond the expected budget cuts, the President's proposal also recommended moving AHRQ from a free-standing agency in the Department of Health and Human Services (HHS) to a component of the National Institutes of Health (NIH) and renaming it the National Institute of Research on Safety and Quality (NIRSQ). The President's FY18 proposed budget also made this recommendation, but it never gained traction.

The FY19 proposals from the House and Senate Appropriations Committees recommend no change in AHRQ's budget compared with FY18, although the funding legislation is still pending at the time of this writing. Looking forward, the President is already threatening a government shutdown by vetoing any spending bill that does not include funds for building his wall. This could once again put AHRQ in danger of funding cuts if the legislation is not passed.

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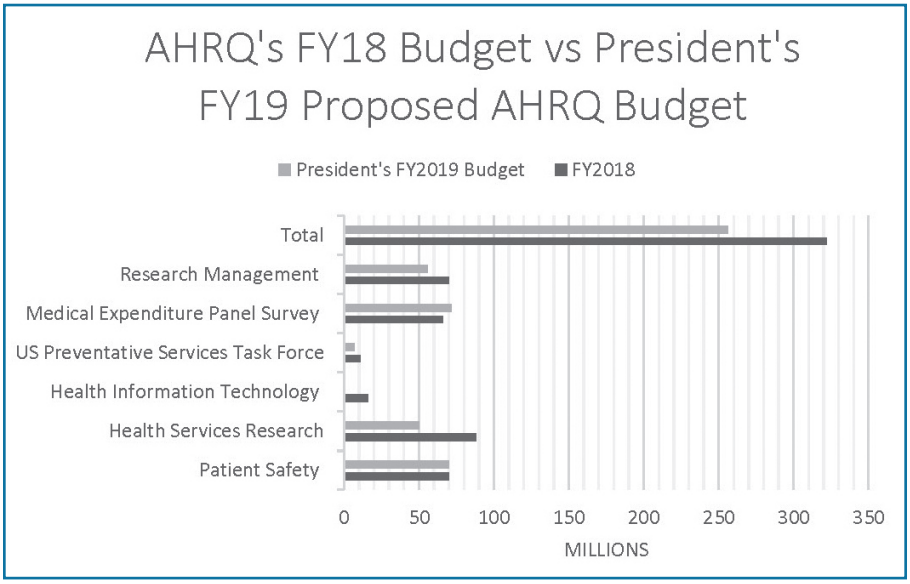

AHRQ's FY18 budget vs President's proposed FY19 budget. Modified from https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/about/mission/budget/2019/NIRSQ.pdf

Foreseeing the political battle over the budget and the impact it may have on the future of health services research, it's important to better understand the president's proposal to move AHRQ to the NIH and understand why health services research funding, which is crucial to the success of our healthcare system, continues to be threatened.

I spoke with Dr. Andy Bindman, former AHRQ director under President Obama, to help answer these questions.

Me: What are the benefits of having health services research at the NIH?

Andy Bindman: Right now, the NIH has already been funding tremendous efforts in health services research in projects such as the National Institute of Aging and the National Cancer Institute. Yet, I don't know if their efforts are well coordinated for the larger efforts made in health services research, which AHRQ is very good at. But it's been hard to bridge these efforts with AHRQ being a separate institute. A benefit of having AHRQ at the NIH would be better coordination of health services research between departments in the NIH and a dedicated department where this type of research is the main focus.

Me: Why does health services research, which is so critical to improving our healthcare system, not get the same support as biomedical research?

Andy Bindman: Biomedical research funds projects that are tied with industry and leads to new drugs that go into the market place to be sold… Health services research helps make our healthcare system more intelligent. But most of our incentives in the market place are not geared that way, towards rewarding value... Nobody at first blush would say they are against value but there are a lot of people who are gaining by working in this current volume-based system, and thus it's hard to find support for increasing incentives towards a value-based care system, and therefore funding health services research.

Me: How can groups like SGIM help support health services research, and make the key stakeholders aware of its value in improving our healthcare system?

Andy Bindman: It's not just about having stakeholders support health services research, it's about having stakeholders seeing health services research as one of its top priorities… When I was first director of AHRQ I went to a meeting at the AAMC [Association of American Medical Colleges], who is a big stakeholder, and they listed their top three priorities for Congress that year. The NIH was on the list, but AHRQ and health services research was not. My goal was to have AHRQ and health services research get on that list. Doing so helps Congress and other stakeholders wake up to the importance of this work. One issue in achieving this goal is that health services researchers often talk amongst themselves but not to the end users... When a drug gets discovered and cures a disease its easy to draw a line from biomedical research to the outcome. This helps emphasize the importance of biomedical research. But when you prevent a medical error or improve the quality of a healthcare treatment, who knows that health services research lead to this outcome? Health services researchers and groups like SGIM need to focus on making stakeholders aware of the impact of health services research, if they want to see continued support and become a top priority among important stakeholders.

The possibility of moving AHRQ to the NIH is uncertain, and would require authorizing legislation, which does not appear likely in the immediate future. However, threats of funding cuts should remind us that health services research is not on the priority list of enough important stakeholders. By following Dr. Bindman's advice, clearly summarizing our successes in health services research and their associations with improved healthcare outcomes, we will better

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acknowledge its significance. Wanting to end the opioid epidemic or prevent another medical error from taking a life is not a partisan debate; neither should be supporting health services research and AHRQ. The members of groups such as SGIM, who can inform policy makers, need to continue to advocate for AHRQ and the crucial research it funds.

References

1. Makary MA, Daniel M. 2016. Medical error-the third leading cause of death in the US. *BMJ*. 353:i2139. doi: 10.1136/bmj.i2139.
2. Seth P, Rudd RA, Noonan RK, et al. Quantifying the epidemic of prescription opioid overdose deaths. *Am J Public Health*. 2018 Apr;108(4):500-502. doi: 10.2105/AJPH.2017.304265. Accessed September 1, 2018.
3. Henriksen K, Dymek C, Harrison MI, et al. Challenges and opportunities from the Agency for Healthcare Research and Quality (AHRQ) research summit on improving diagnosis: a proceedings review. *Diagnosis*. 2017;4(2):57-66.
4. Meyers D, Miller T, Genevro T, et al. EvidenceNOW: Balancing Primary Care Implementation and Implementation Research. *Ann Fam Med*. 16 (Suppl 1):S5-S11. doi: 10.1370/afm.2196.
5. Department of Health and Human Services. FY 2019 HHS Presidents Budget Proposal. https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf. Last updated February 19, 2018. Accessed September 1, 2018. SGIM