Editorial

Health Services Research: From Galvanizing Attention to Creating Action

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In 1991, a simple, yet powerful, symbol premiered in New York that has become the most identifiable representation of the fight against AIDS—the red ribbon. In the ensuing 12 years, the red AIDS ribbon has been joined by a score of ribbons in different colors, each signifying a different cause: pink for a breast cancer cure, white to combat violence against women, a multi-color puzzle pattern for the fight against autism.

These symbols work because they do more than just galvanize public support. They are very evocative images of a commitment to go beyond identifying a need; the ribbon represents a desire and force for change. This substance and commitment are what make these symbols effective and enduring.

Health services research can learn a great deal from the simple red ribbon. Over the years, as health services researchers, we have done a very good job of identifying critical issues and problems in the American health care system, such as the numbers of the uninsured, problems with patient safety, inequitable distribution of health care resources, and the potential savings to the Medicare program associated with regional variations (Fisher et al. 2003). These successes correspond to John Kingdon's concept of identifying policy problems, as summarized in the Chair's address in this issue (Feder 2003).

Each of these issues has galvanized public opinion and spurred debate. For example, the problem of the uninsured has been an issue in countless national and local elections. The incidence of medical errors specifically, and the problems with patient safety in general, generated a firestorm of media attention after the 1999 release of the Institute of Medicine report *To Err Is Human* (Kohn, Corrigan, and Donaldson 1999). Rising health care costs and the inadequate distribution of health care resources are the frequent subject of editorials and public opinion polls. Similarly, the existence and persistence of disparities in health care associated with race, ethnicity and

socioeconomic position have sparked extensive dialogue (Smedley, Stith, and Nelson 2002).

Health services researchers should be very proud of the excellent research and analysis that have brought science and evidence into the debate about these and other significant issues facing the American health care system. Without research and debate, there would be no attention to these issues, nor would there have been any catalyst for change or improvement.

However, a critical challenge facing the field of health services research in general, and the Agency for Healthcare Research and Quality (AHRQ) specifically, is to make sure that we don't lose sight of the next step: to go beyond simply identifying a problem to doing what needs to be done to make a difference. In other words, health services research must go beyond galvanizing attention to galvanizing action.

I recognize that this is not as simple as it sounds. There are barriers, significant but not insurmountable, to meeting this challenge. One barrier is funding, and AHRQ is working to ensure that the studies we support include a component involving knowledge transfer and implementation so we can translate research into practice. To that end, AHRQ also is continuing to focus on partnership in everything from collaborating with other funders, to leverage our resources, to supporting our partners' efforts to accelerate the adoption of research findings.

An excellent example of this is a program that we launched in November 2002 called the Partnerships for Quality. We funded a coordinated set of 22 projects to develop partnerships among researchers, health plans, medical and nursing facilities and services, employers, consumer groups, and professional societies to test prototype activities aimed at speeding up the use of research findings that have been shown to improve quality of care for patients. For more information, got to http://www.ahrq.gov/news/press/pr2002/poqpr.htm. This will serve as a model for future AHRQ initiatives.

Ironically, many of the barriers we face result from a lack of the right kind of research. We know more about measuring quality than we do about improving quality. We have learned a lot of facts about access to services and their costs, and researchers have done superb work to identify the likely impacts of alternative approaches to expanding access, but we don't really know how to get more value for the health care dollars we spend. Moreover, we have not always been as flexible as needed in letting decision makers know when the "policy window" opens. Steve Soumerai's case study of the limited time and capacity available to state policymakers for using relevant evidence confronting state policy makers provides a stark reminder that relevant

findings may not be used in real time (Soumerai 1997) Assuming the existence of "receptor sites" for relevant research is appealing but unlikely to result in timely use of the information.

We need to work together to ensure that health services research addresses the issues and questions that will lead to change, and that as funders and researchers we help ensure that findings are used to improve the health care system. Making sure that we conduct relevant studies *and* that the results are used by decision makers represents the next quantum leap for the field. Making this leap will require close attention to the needs of decision makers—to get the questions right and to communicate results in a timely and effective fashion.

When there is a clear hand-off between research and action, collaboration can lead to success. An excellent example is the Quality Improvement Organizations (QIOs) and their ongoing activity to improve quality in the Medicare program. This improvement was documented in January 2003 when the Centers for Medicare & Medicaid Services (CMS) released the second evaluation of the quality of care in the Medicare program, based on 22 measures related to primary prevention, secondary prevention, and/or treatment of six medical conditions.

The results, published in the January 16, 2003 issue of the *Journal of the American Medical Association* (Jencks 2003), indicate that a typical beneficiary had a 73 percent chance of receiving appropriate care on a given measure in 2000–01, up from 69 percent in 1998–99. Among other findings, the proportion of patients receiving beta-blockers at hospital discharge rose from 72 percent of appropriate patients to 79 percent, and the proportion of patients receiving an effective combination of antibiotics for pneumonia rose from 79 percent to 85 percent. For the first time, we saw clear evidence linking measurement to improvement and demonstrating that such improvements can be sustained over time.

This success was the result of a multifaceted approach and partnership between researchers, providers, and regulators. AHRQ supported the outcomes research and work to develop many of the measures used in evaluating the quality of care in Medicare. The QIOs collaborated with hospitals, providers, accreditors, beneficiaries, and others to promote the use of research and evidence to improve quality, and followed it up with evaluation using evidence-based measures. The CMS provided support for these efforts and increasingly is basing its reimbursement and regulations on evidence.

As AHRQ's new director, I look forward to building on the Agency's strong foundation of evidence, partnership, and the focus on translating research into practice. We need to grow our successes and to nurture our clear focus on improvement. We have some exciting upcoming projects that will help set the stage for further success.

Last year we launched the second phase of our Consumer Assessment of Health Plans (CAHPS®). The first generation of CAHPS provided a new model of research collaboration across superb research teams, survey users and health system leaders that resulted in a family of surveys that represents excellence for assessing patients' experience of care. Survey development was enhanced and informed by user input at multiple stages, and together the teams have provided the foundation for reporting meaningful information to those the health care system is intended to serve. The new age of CAHPS includes a hospital survey called H-CAHPS, but it also represents an enhancement of the earlier instruments and a clear impetus for using the surveys for improvement and not only for measurement.

The AHRQ will launch two new forces in 2003 in the fight against the epidemic of medical errors. We are funding a Patient Safety Improvement Corps, which responds directly to the calls we've had from states seeking technical assistance to implement best practices in patient safety. We also are supporting a series of "challenge grants" designed to provide funding to states and local organizations to help with the adoption of these practices.

Later this year, AHRQ will publish the first annual *National Report on Healthcare Quality*, which will document successes in achieving quality and where work still needs to be done, and the first *National Report on Healthcare Disparities*, which will document where disparities exist in the health care system. These reports will also start down the next step to creating change by providing the knowledge and tools to help fill the gaps in quality and reduce racial, ethnic, and socioeconomic disparities. Both reports are also likely to reveal gaps in our understanding of how to achieve improvements on a large scale and in our currently limited knowledge base for moving from describing problems to solving them.

This is not the first time you have heard or read a message from an AHRQ director encouraging you to make an impact with your research. As the old adage goes "Anything worth saying is worth saying twice." When Steve Shortell received the prestigious Baxter Award for sustained achievement in health services research, he articulated the urgency of focusing on the science of change. The challenges confronting health care delivery—from inequality in quality, to strategies for providing a prescription drug benefit for

Medicare beneficiaries that promotes safe and effective use of pharmaceuticals, to preparedness for bioterrorism, to name a few—demand both intellectual rigor for assessing what and why, as well as commitment to examining strategies for change that will set the stage for implementing the results.

As a senior associate editor for *Health Services Research*, I am pleased to report that the backlog in publishing worthy articles has been eliminated: the time from article acceptance to publication has never been more rapid. Because of this, the leadership of AcademyHealth, HRET—the publisher of *Health Services Research*, and the editors of *Health Services Research*, have decided to change the way we honor the memory of Alice Hersh. In the past we have published a special electronic issue with articles presented at the Annual Research Meeting of the Academy. This entailed special review processes that both stressed our system and did not allow authors the time to revise and resubmit their papers. This tradeoff was worthwhile when there was a long time from acceptance to publication. With the backlog eliminated, we now invite all papers to be submitted through our usual (and more rapid) process. In place of the special issue, we will specifically invite the winners of the best dissertation and best student presentation awards to submit their papers for peer review by some of our best reviewers. We will also highlight some of the panel and policy discussions that would not normally be submitted as empirical papers.

As director of AHRQ, I pledge to be your partner in galvanizing attention and creating action and I seek your feedback on accelerating our progress.

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