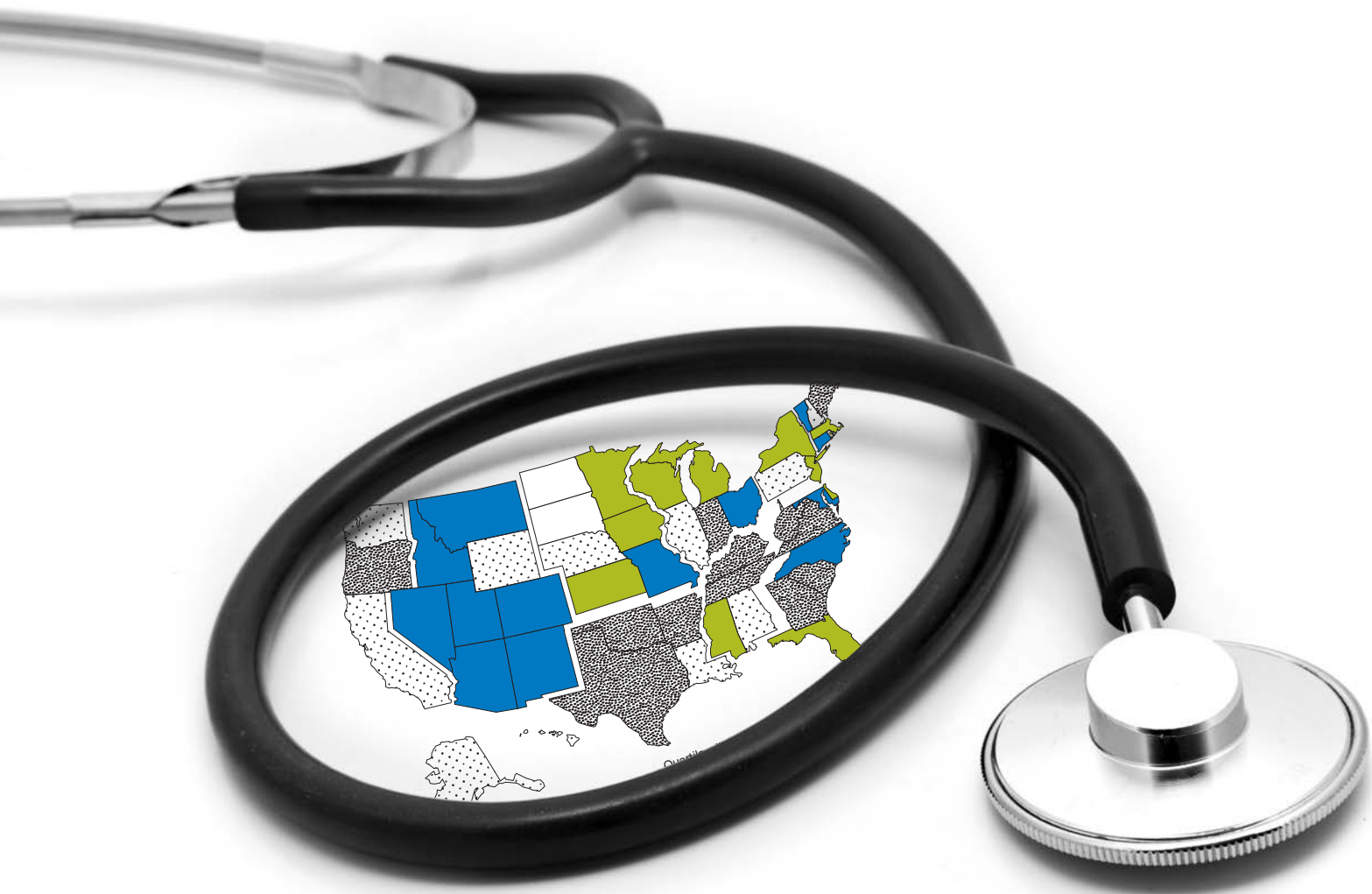




2014 National Healthcare Quality and Disparities Report



Agency for Healthcare Research and Quality

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2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**
Agency for Healthcare Research and Quality
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EXECUTIVE SUMMARY

The National Healthcare Quality and Disparities Reports are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the health care system along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy (NQS). The reports are based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Data are generally available through 2012, although rates of uninsurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on health care quality and health care disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of health care. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The new QDR and supporting chartbooks are further integrated with the NQS. The NQS has three overarching aims that build on the Institute for Healthcare Improvement's Triple Aim[®] and that support HHS's delivery system reform initiatives to achieve better care, smarter spending, and healthier people through incentives, information, and the way care is delivered. These aims are used to guide and assess local, state, and national efforts to improve health and the quality of health care. To advance these aims, the NQS focuses on six priorities that address the most common health concerns that Americans face. Quality measures tracked in the QDR have been reorganized around these priorities and a chartbook will be released marking progress for each NQS priority.

Key Findings of the 2014 Quality and Disparities Report

The report demonstrates that the nation has made clear progress in improving the health care delivery system to achieve the three aims of better care, smarter spending, and healthier people, but there is still more work to do, specifically to address disparities in care.

- Access improved.
 - After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.
 - Through 2012, improvement was observed across a broad spectrum of access measures among children.
- Quality improved for most NQS priorities.
 - *Patient Safety* improved, led by a 17% reduction in rates of hospital-acquired conditions between 2010 and 2013, with 1.3 million fewer harms to patients, an estimated 50,000 lives saved, and \$12 billion in cost savings.
 - *Person-Centered Care* improved with large gains in patient-provider communication.
 - Many *Effective Treatment* measures, including several measures of pneumonia care in hospitals publicly reported by the Centers for Medicare & Medicaid Services (CMS), achieved such high levels of performance that continued reporting is unnecessary.
 - *Healthy Living* improved, led by doubling of selected adolescent immunization rates from 2008 to 2012.
- Few disparities were eliminated.
 - People in poor households generally experienced less access and poorer quality.
 - Parallel gains in access and quality across groups led to persistence of most disparities.
 - At the same time, several racial and ethnic disparities in rates of childhood immunization and rates of adverse events associated with procedures were eliminated, showing that elimination is possible.
- Many challenges in improving quality and reducing disparities remain.
 - Performance on many measures of quality remains far from optimal. For example, only half of people with high blood pressure have it controlled. On average, across a broad range of measures, recommended care is delivered only 70% of the time.
 - As noted above, disparities in quality and outcomes by income and race and ethnicity are large and persistent, and were not, through 2012, improving substantially.
 - Some disparities related to hospice care and chronic disease management grew larger.
 - Data and measures need to be improved to provide more complete assessments of two NQS priorities, *Care Coordination* and *Care Affordability*, and of disparities among smaller groups, such as Native Hawaiians, people of multiple races, and people who are lesbian, gay, bisexual, or transgender.

Summary: Access and Access Disparities

- After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.
- During the first half of 2014, declines in rates of uninsurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.
- Through 2012, improvement was observed across a broad spectrum of access measures among children but less so among adults ages 18-64.
- Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Summary: Quality and Quality Disparities

- Quality of health care improved generally through 2012, but the pace of improvement varied by measure.
- Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.
- Disparities in quality of care remained prevalent and few disparities were eliminated.
- Overall quality and racial/ethnic disparities varied widely across states, and often not in the same direction. Southern states tended to have poorer quality but smaller disparities while Middle Atlantic and West North Central states tended to have higher quality but larger disparities.

Summary: National Quality Strategy Priorities

- The National Quality Strategy has six priorities: Patient Safety, Person-Centered Care, Care Coordination, Effective Treatment, Healthy Living, and Care Affordability.
- Half of *Patient Safety* measures improved,ⁱ led by a 17% reduction in rates of hospital-acquired conditions.
- *Person-Centered Care* improved steadily, especially for children.
- *Care Coordination* improved as providers enhanced discharge processes and adopted health information technologies.
- *Effective Treatment* in hospitals achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.
- *Healthy Living* improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.
- *Care Affordability* worsened from 2002 to 2010 and then leveled off.

ⁱ We use “measures improved” as shorthand to indicate that performance on measures showed improvement and “measures got worse” as shorthand to indicate that performance on measures showed worsening.

BACKGROUND

Each year since 2003, AHRQ has reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the report focuses on “national trends in the quality of health care provided to the American people” (42 U.S.C. 299b-2(b)(2)) and “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations” (42 U.S.C. 299a-1(a)(6)). The report is produced with the support of an HHS Interagency Work Group and guided by input from AHRQ’s National Advisory Council and the Institute of Medicine.

As in previous years, the 2014 report tracks more than 250 health care process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2011-2012. It is important to note that the report provides a snapshot of health care prior to implementation of most of the health insurance expansions included in the Affordable Care Act and serves as a baseline to track progress in upcoming years. An exception is rates of uninsurance, which we were able to track through the first half of 2014.

CHANGES IN THE 2014 QUALITY AND DISPARITIES REPORT

We substantially reorganized the 2014 National Healthcare Quality and Disparities Report in response to feedback from readers to make it more usable while continuing to make available the data and analyses included in previous reports. We reviewed suggestions from AHRQ leadership, the Interagency Work Group, AHRQ’s National Advisory Council, NQS Implementation staff, and the Institute of Medicine related to focus, content, format, and dissemination.

The result of this input was a number of design principles that maximize value to potential users of this 2014 QDR.

- The report emphasizes analyses of change over time to assess performance and to distinguish areas that are improving from those that may benefit from additional attention. While many groups provide report cards on health and health care in the United States at a point in time, QDR data support trends across a broad array of quality measures for a wide variety of health care services and settings.
- Integration with the NQS is enhanced. The NQS identifies quality improvement priorities for the nation and reports on promising initiatives to make health care better. The 2014 QDR is reorganized around tracking progress for each of the six NQS priorities. It also tracks access to health care, which is not part of the NQS framework.
- The importance of simultaneously considering both performance and disparities is reinforced. Instead of two separate reports, the 2014 QDR provides a more complete and integrated assessment of access to and quality of health care. As specified in the Healthcare Research and Quality Act of 1999, it continues to focus on disparities related to race, ethnicity, and socioeconomic status. The new QDR also incorporates analyses of other priority populations, including women, children, older adults, people with disabilities and at the end of life, and residents of rural areas and inner cities.

- Electronic dissemination is expanded, recognizing that the vast majority of QDR users prefer the website to paper documents. This allows the paper document to be shortened and to focus on summarizing information for policymakers. Analyses of individual measures will be disseminated on the Web (www.ahrq.gov/research/findings/nhqdrdr/2014chartbooks/). Additional information on each priority population will also be posted on the QDR website.

KEY FINDINGS

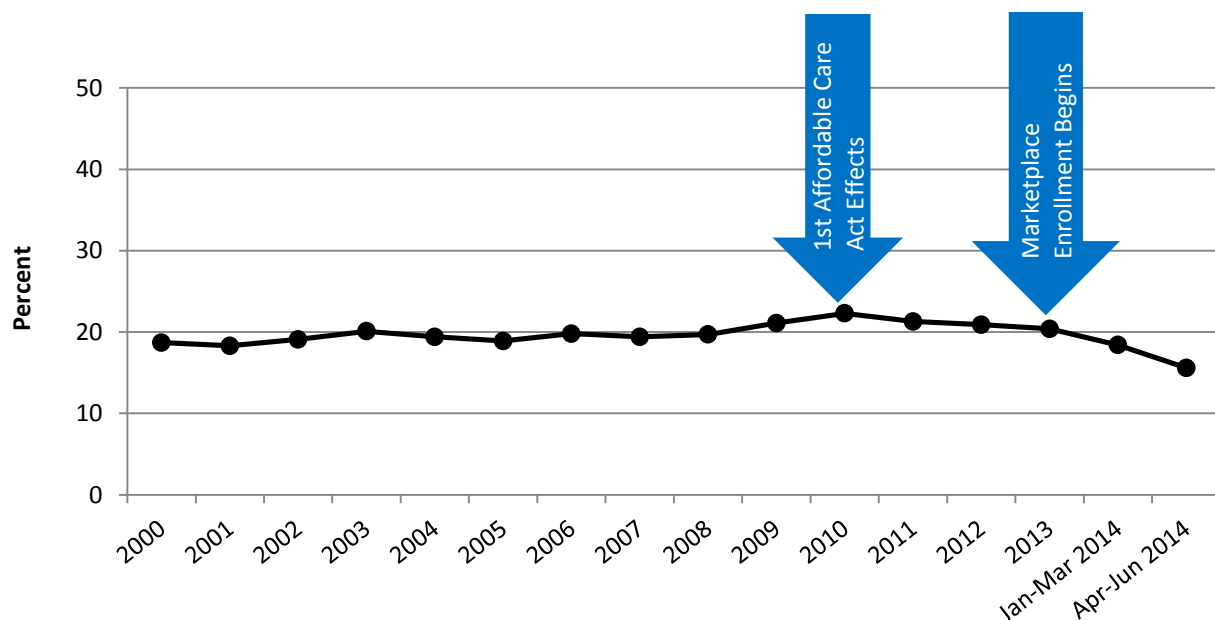
The key findings of the 2014 QDR are organized around three axes: access to health care, quality of health care, and NQS priorities.

Access and Access Disparities

To obtain high-quality care, Americans must first gain entry into the health care system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.

Adults ages 18-64 who were uninsured at the time of interview, 2000-2014



Source: National Center for Health Statistics, National Health Interview Survey, 2000-June 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage

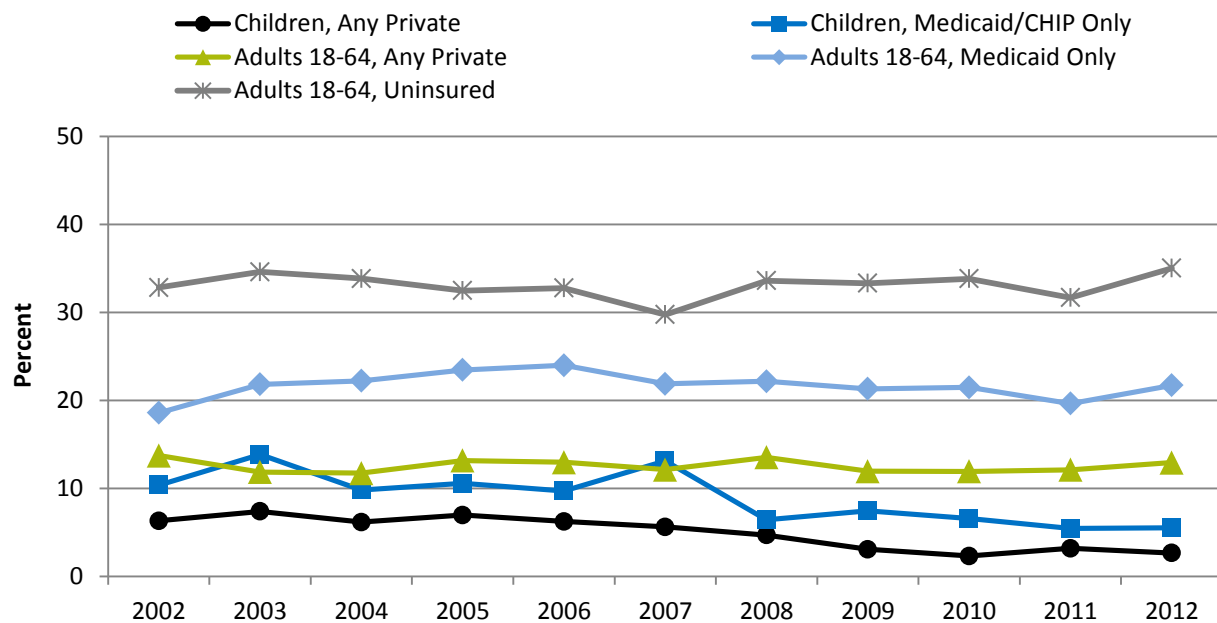
began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,¹ consistent with these trends.

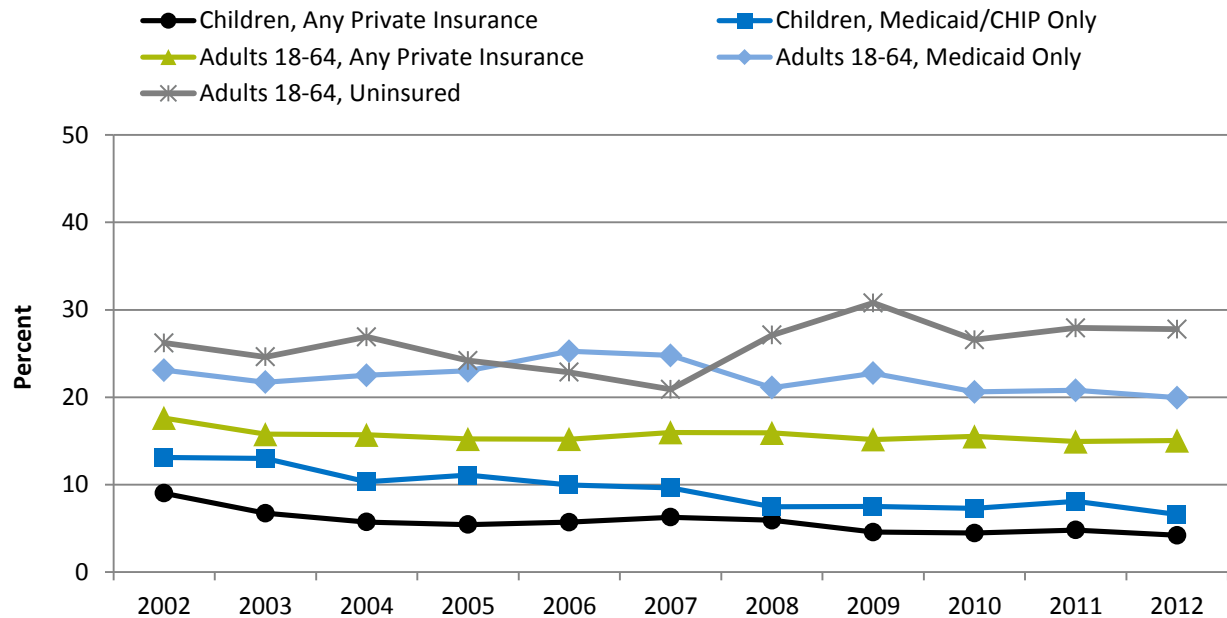
ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

People who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.

People who made an appointment for routine health care in the last 12 months who sometimes or never got an appointment as soon as wanted, by age and insurance, 2002-2012



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.

Trends

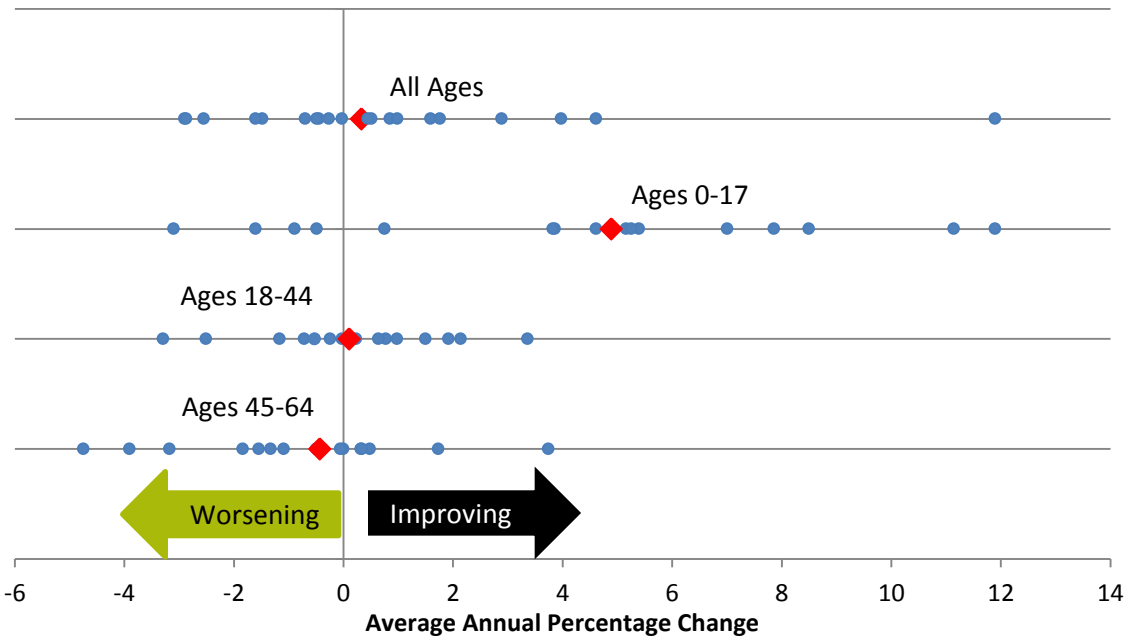
- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

ACCESS: Through 2012, improvement was observed across a broad spectrum of access measures among children but less so among adults ages 18-64.

Average annual rates of change of access to care measures through 2012, by age



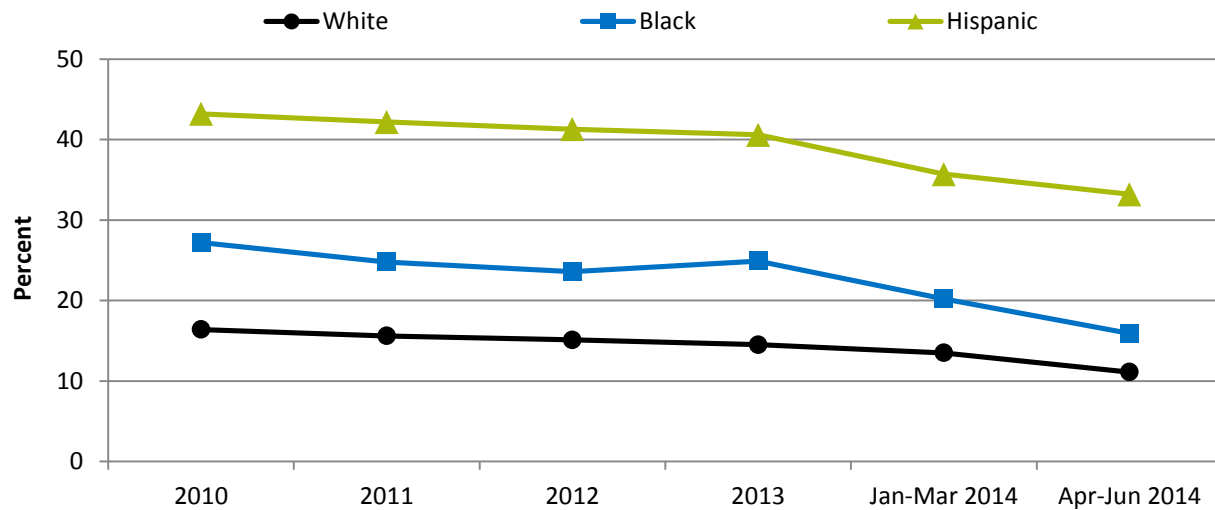
Note: Each point represents one measure. Large red diamonds indicate median values. Access measures include insurance, usual provider, barriers to care, and timeliness of care. For the vast majority of measures, trend data are available from 2001-2002 to 2012. For each measure with at least four estimates over time, weighted log-linear regression is used to calculate average annual percentage change. Measures are aligned so that positive change indicates improved access to care.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of uninsurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Adults ages 18-64 who were uninsured at the time of interview, by race/ethnicity, 2010-2014



Source: National Center for Health Statistics, National Health Interview Survey, 2010-June 2014.

Trends

- Historically, Blacks and Hispanics have had higher rates of uninsurance than Whites.ⁱⁱ

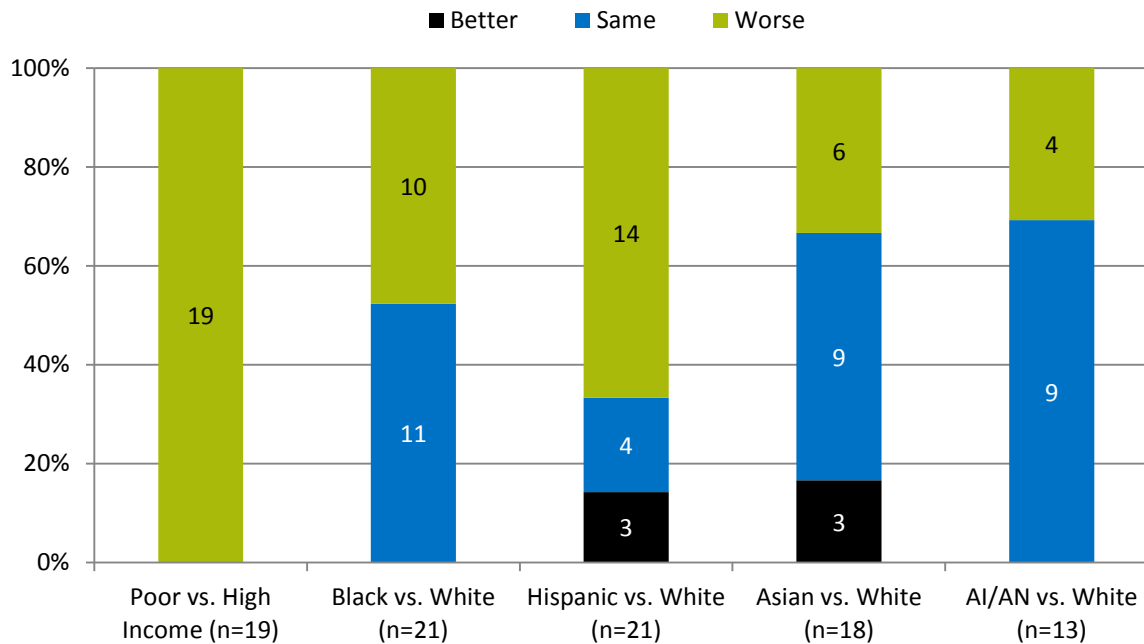
Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in uninsurance rates between groups remained.
- Data from the Urban Institute’s Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.²

ⁱⁱ In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities: Access measures for which members of selected groups experienced better, same, or worse access to care compared with reference group, 2012



Key: AI/AN = American Indian or Alaska Native; n = number of measures.
Note: Poor indicates family income less than the federal poverty level; High Income indicates family income four times the federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. Measures that achieve an overall performance level of 95% or better are not reported in the QDR and are not included in these analyses. Because disparities are typically eliminated when overall performance reaches 95%, our analyses may overstate the percentage of measures exhibiting disparities.

The relative difference between a selected group and its reference group is used to assess disparities.

- **Better** = Population had better access to care than reference group. Differences are statistically significant, are equal to or larger than 10%, and favor the selected group.
- **Same** = Population and reference group had about the same access to care. Differences are not statistically significant or are smaller than 10%.
- **Worse** = Population had worse access to care than reference group. Differences are statistically significant, are equal to or larger than 10%, and favor the reference group.

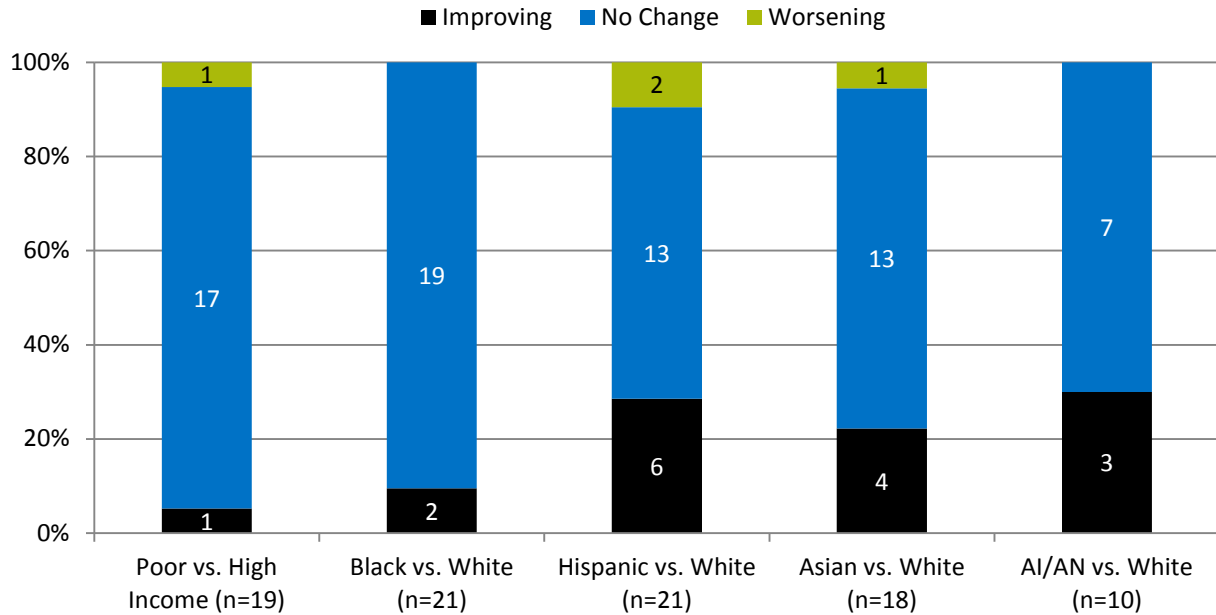
Example: Compared with Whites, Hispanics had worse access to care on 14 of the 21 access measures, similar access on 4 measures, and better access on 3 measures.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Change in Disparities: Number and percentage of all access measures for which disparities related to race, ethnicity, and income were improving, not changing, or worsening, through 2012



Key: AI/AN = American Indian or Alaska Native; n = number of measures.

Note: Poor indicates family income less than the federal poverty level; High Income indicates family income four times the federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. For the vast majority of measures, trend data are available from 2001-2002 to 2012.

For each measure, average annual percentage changes were calculated for select populations and reference groups. Measures are aligned so that positive rates indicate improvement in access to care. Differences in rates between groups were used to assess trends in disparities.

- **Worsening** = Disparities are getting larger. Differences in rates between groups are statistically significant and reference group rates exceed population rates by at least 1% per year.
- **No Change** = Disparities are not changing. Differences in rates between groups are not statistically significant or differ by less than 1% per year.
- **Improving** = Disparities are getting smaller. Differences in rates between groups are statistically significant and population rates exceed reference group rates by at least 1% per year.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- In four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

Quality and Quality Disparities

Measures of health care quality tracked in the QDR encompass a broad array of services, including prevention, acute treatment, and chronic disease management, and settings, including doctors' offices, emergency departments, dialysis centers, hospitals, nursing homes, hospices, and home health. Most QDR quality measures quantify processes that make up high-quality health care or outcomes related to receipt of high-quality health care. A few structural measures are included, such as the availability of health information technologies and diverse workforces.

Data used to generate QDR measures include results from more than three dozen datasets that provide estimates for various population subgroups and data years. Sources used to assess health care quality in the reports include:

- Surveys of patients, patients' families, and providers;
- Administrative data from health care facilities;
- Abstracts of clinical charts;
- Registry data; and
- Vital statistics.

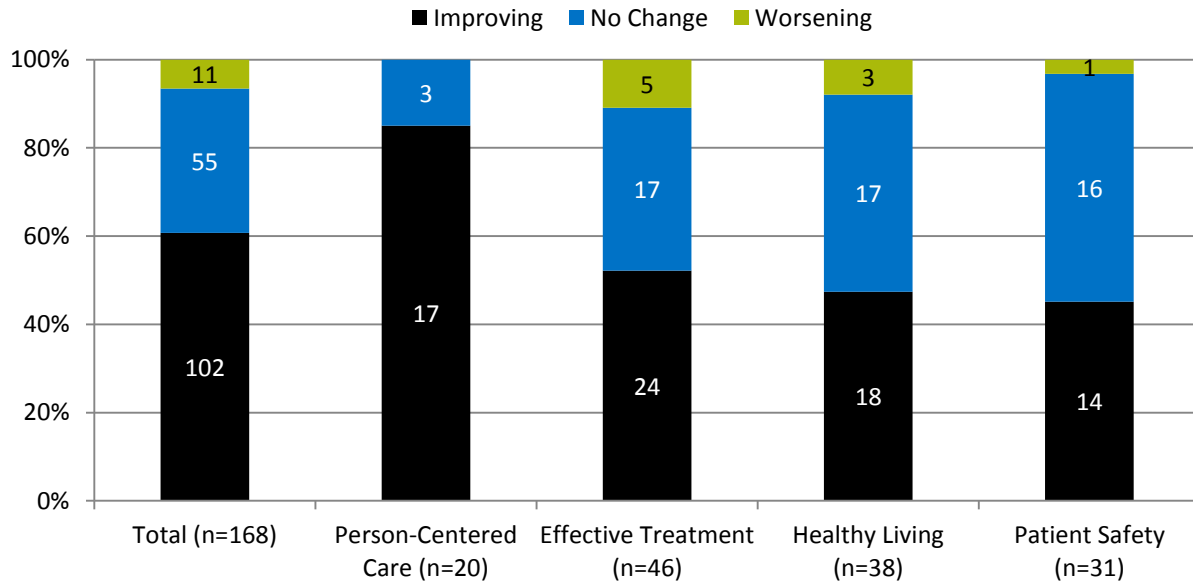
Most data are reported annually and are generally available through 2012.

Historically, quality of health care has varied based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location. As specified in the Healthcare Research and Quality Act, this summary focuses on disparities related to race and socioeconomic status.

With the passage of the Affordable Care Act, HHS was charged with identifying national priorities and developing and implementing a National Quality Strategy to improve the delivery of health care services, patient health outcomes, and population health. This section presents summary data across the six priorities. The last section provides more detail about each NQS priority.

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Number and percentage of all quality measures that are improving, not changing, or worsening through 2012, overall and by NQS priority



Key: n = number of measures.

Note: For the majority of measures, trend data are available from 2001-2002 to 2012.

For each measure with at least four estimates over time, weighted log-linear regression is used to calculate average annual percentage change and to assess statistical significance. Measures are aligned so that positive change indicates improved access to care.

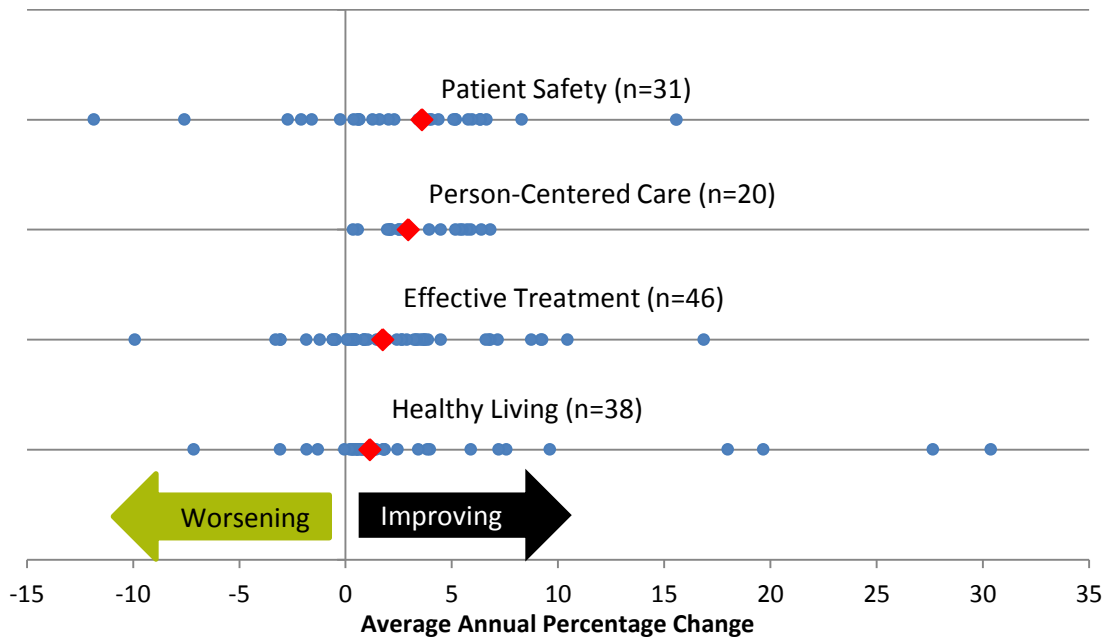
- **Improving** = Rates of change are positive at 1% per year or greater and statistically significant.
- **No Change** = Rate of change is less than 1% per year or not statistically significant.
- **Worsening** = Rates of change are negative at -1% per year or greater and statistically significant.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Average annual rates of change of quality of care measures through 2012, by National Quality Strategy priority



Key: n = number of measures.

Note: Each point represents one measure. Large red diamonds indicate median values. For each measure with at least four estimates over time, weighted log-linear regression is used to calculate average annual percentage change. Measures are aligned so that positive change indicates improved quality of care.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities.
 - Median change in quality was 3.6% per year among measures of Patient Safety.
 - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
 - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
 - Median improvement in quality was 1.1% per year among measures of Healthy Living.
 - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (**bold**).

- **Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes**
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- **Hospital patients with pneumonia who had blood cultures before antibiotics were administered**
- **Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination**
- **Hospital patients age 50+ with pneumonia who received influenza screening or vaccination**
- **Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge**
- **Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations**
- **Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival**
- Adults with HIV and CD4 cell counts of 200 or less who received *Pneumocystis* pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (**bold**).

- **Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine**
- **Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine**
- Hospital patients with heart failure who were given complete written discharge instructions
- **Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine**
- **Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine**
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

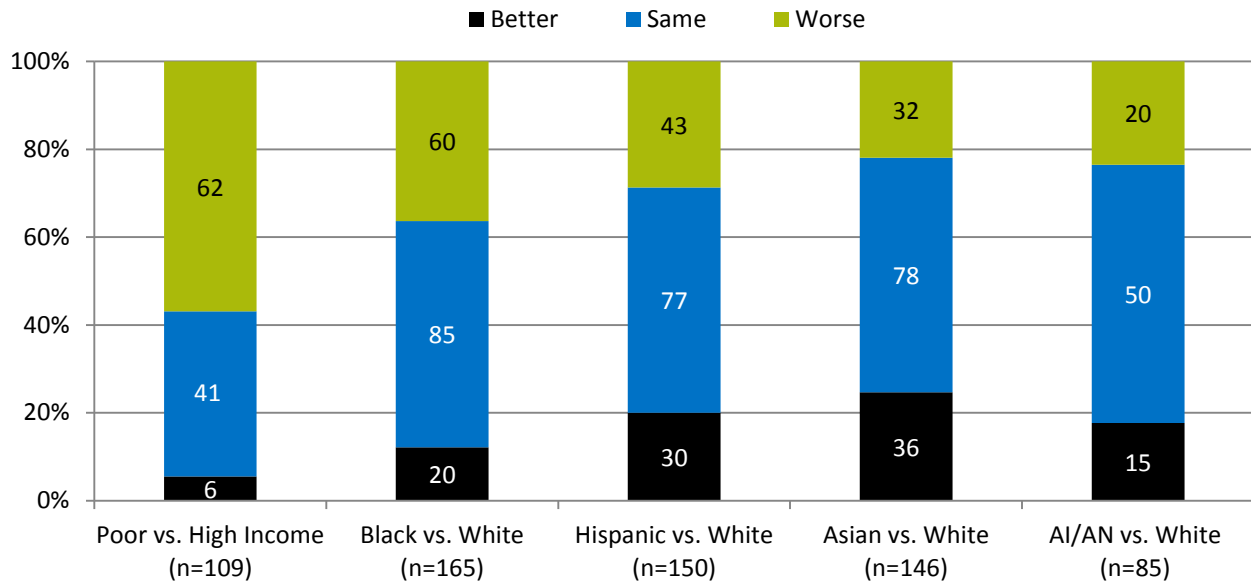
Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (**bold**). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of *Haemophilus influenzae* type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- **Admissions with diabetes with short-term complications per 100,000 population, age 18+**
- **Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year**
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- **People with current asthma who are now taking preventive medicine daily or almost daily**
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities: Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with reference group



Key: AI/AN = American Indian or Alaska Native; n = number of measures.

Note: Poor indicates family income less than the federal poverty level; High Income indicates family income four times the federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. For the majority of measures, data from 2012 are shown. Measures that achieve an overall performance level of 95% or better are not reported in the QDR and are not included in these analyses. Because disparities are typically eliminated when overall performance reaches 95%, our analyses may overstate the percentage of measures exhibiting disparities.

The relative difference between a selected group and its reference group is used to assess disparities.

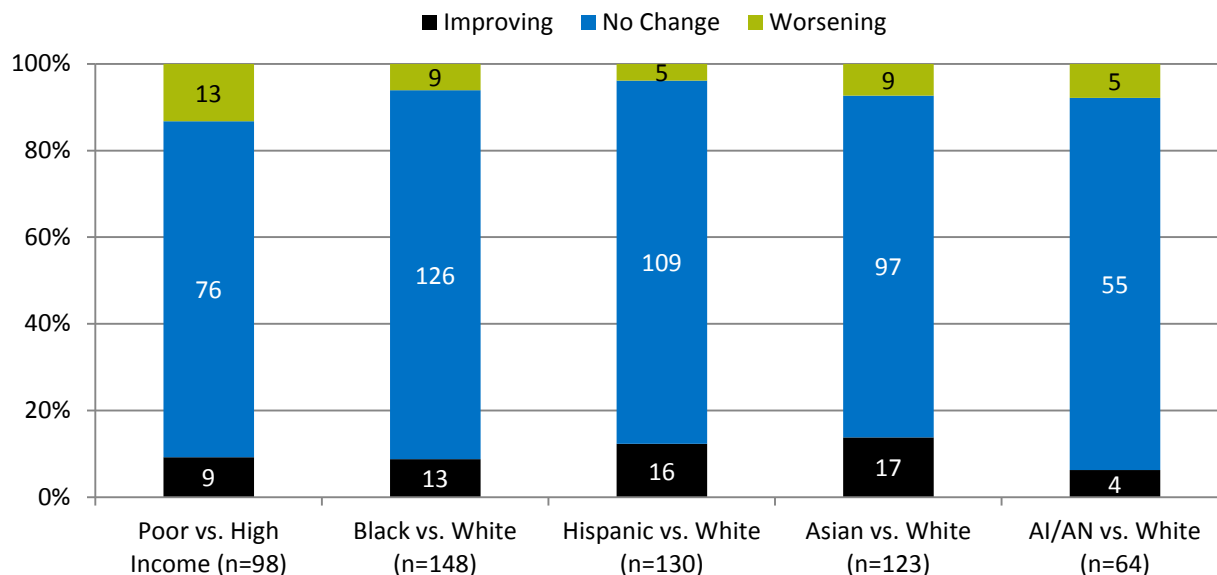
- **Better** = Population received better quality of care than reference group. Differences are statistically significant, are equal to or larger than 10%, and favor the selected group.
- **Same** = Population and reference group received about the same quality of care. Differences are not statistically significant or are smaller than 10%.
- **Worse** = Population received worse quality of care than reference group. Differences are statistically significant, equal to or larger than 10%, and favor the reference group.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems (see p. 7 for disparities in access).

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Change in Disparities: Number and percentage of quality measures for which disparities related to race, ethnicity, and income were improving, not changing, or worsening through 2012



Key: AI/AN = American Indian or Alaska Native; n = number of measures.

Note: Poor indicates family income less than the federal poverty level; High Income indicates family income four times the federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. For the majority of measures, trend data are available from 2001-2002 to 2012.

For each measure, average annual percentage changes were calculated for select populations and reference groups. Measures are aligned so that positive rates indicate improvement in access to care. Differences in rates between groups were used to assess trends in disparities.

- **Worsening** = Disparities are getting larger. Differences in rates between groups are statistically significant and reference group rates exceed population rates by at least 1% per year.
- **No Change** = Disparities are not changing. Differences in rates between groups are not statistically significant or differ by less than 1% per year.
- **Improving** = Disparities are getting smaller. Differences in rates between groups are statistically significant and population rates exceed reference group rates by at least 1% per year.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Table 1. Disparities in health care quality that were eliminated or worsened over time

Groups	Disparities Eliminated	Disparities Worsened
Black compared with White	Mechanical adverse events in patients receiving central venous catheter placement, age 18+	Adult current smokers with a checkup in the past year who received advice in the last 12 months to quit smoking
	Hospital patients with an anticoagulant-related adverse drug event to low-molecular-weight heparin and factor Xa, age 18+	Breast cancer diagnosed at advanced stage per 100,000 women age 40+
	Children ages 19-35 months who received 1+ doses of measles-mumps-rubella vaccine	People age 12+ who needed treatment for illicit drug use and who received treatment at a specialty facility in the last 12 months
	Deaths per 1,000 hospital admissions with abdominal aortic aneurysm repair, age 18+	Family caregivers who did not want more information about what to expect while the patient was dying
	Postoperative respiratory failure per 1,000 elective-surgery admissions, age 18+	
	Admissions with iatrogenic pneumothorax per 1,000 admissions, age 18+	
Asian compared with White	Adults age 40+ with diagnosed diabetes who had their feet checked in the calendar year	Admissions with iatrogenic pneumothorax per 1,000 admissions, age 18+
	Adults age 40+ with diagnosed diabetes who received a dilated eye examination in the calendar year	
	Adults age 65+ who received an influenza vaccination in the last 12 months	
	Adult hospital patients who sometimes or never had good communication with doctors	
	Patients under age 70 with treated chronic kidney failure who received a transplant within 3 years of date of renal failure	
	Adults who had a visit in the last 12 months whose health providers sometimes or never listened carefully to them	
AI/AN compared with White	Children ages 19-35 months who received 3 or more doses of hepatitis B vaccine	Hospice patient caregivers who perceived patient was referred to hospice at right time

Groups	Disparities Eliminated	Disparities Worsened
Hispanic compared with Non-Hispanic White	Adults with obesity who ever received advice from a health professional about eating fewer high-fat foods	Hospice patients who received care consistent with their stated end-of-life wishes
		Hospice patients who received the right amount of medicine for pain management
Poor compared with High Income	Adolescent females ages 13-15 years who received 3+ doses of human papillomavirus vaccine	Adults age 40+ with diagnosed diabetes who received 2+ hemoglobin A1c measurements in the calendar year
		Adults with chronic joint symptoms who have ever seen a doctor or other health professional for joint symptoms

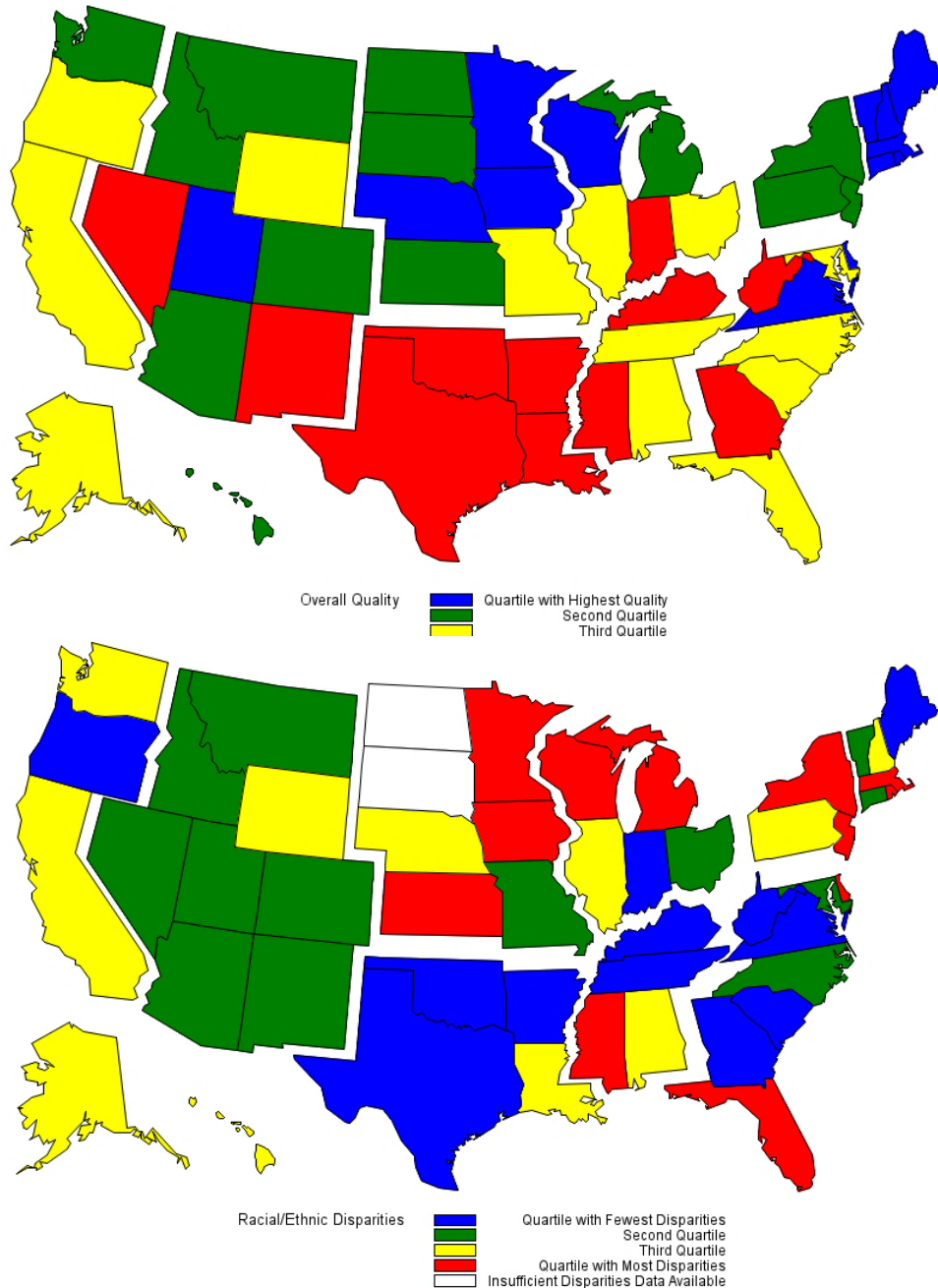
Note: **Blue** = hospital adverse events; **green** = vaccinations; **gray** = chronic disease measures; **light blue** = communication measures; **light green** = hospice measures. Disparities Eliminated indicates measures with significant population differences in the past that have been reduced to zero. Disparities Worsened indicates measures for which the population rate decreased as the reference group rate increased. For the majority of measures, trend data are available from 2001-2002 to 2012.

Disparities Trends (Table 1)

- Through 2012, several disparities were eliminated.
 - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
 - Four disparities related to hospital adverse events were eliminated for Blacks.
 - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
- On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
 - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
 - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

States sorted by overall quality (top) and average differences between Blacks, Hispanics, and Asians compared with Whites (bottom).



Source: Agency for Healthcare Research and Quality, 2013 State Snapshots.

Note: An overall quality score is computed for each state based on the number of quality measures that are above, at, or below the average across all states; states are ranked and quartiles are shown in the top map. To assess disparities, separate quality scores are computed for Whites, Blacks, Hispanics, and Asians. For each state, the average of the Black, Hispanic, and Asian scores is divided by the White score; states are ranked on this ratio and quartiles are shown in the bottom map. See State Snapshots at <http://nhqrnet.ahrq.gov/inhqdr/state/select> for more detailed methods.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality (blue and green) while states in the South census region tended to have lower quality (yellow and red).
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities (blue and green) while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities (yellow and red).
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

The State Snapshots tool (<http://nhqrnet.ahrq.gov/inhqrdr/state/select>), part of the QDR website, focuses on variation across states and helps state health leaders, researchers, and consumers understand the status of health care in individual states and the District of Columbia. It is based on more than 100 QDR measures for which state estimates are possible. Data from the 2013 State Snapshots were used to rank each state by overall quality and by the average difference between Blacks, Hispanics, and Asians compared with Whites.

National Quality Strategy

Mandated by the Affordable Care Act, the NQS was developed through a transparent and collaborative process with input from a range of stakeholders. More than 300 groups, organizations, and individuals, representing all sectors of the health care industry and the general public, provided comments. Based on this input, the NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim[®].

These aims are consistent with and supportive of HHS's delivery system reform initiatives to achieve better care, smarter spending, and healthier people through incentives, information, and the way care is delivered. The aims are used to guide and assess local, state, and national efforts to improve health and the quality of health care:

- *Better Care*: Improve overall quality by making health care more patient centered, reliable, accessible, and safe.
- *Healthy People/Healthy Communities*: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care.
- *Affordable Care*: Reduce the cost of quality health care for individuals, families, employers, and government.

To advance these aims, the NQS focuses on six priorities that address the most common health concerns that Americans face:

- *Patient Safety*: Making care safer by reducing harm caused in the delivery of care.
- *Person-Centered Care*: Ensuring that each person and family is engaged as partners in their care.
- *Care Coordination*: Promoting effective communication and coordination of care.
- *Effective Treatment*: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- *Healthy Living*: Working with communities to promote wide use of best practices to enable healthy living.
- *Care Affordability*: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

To align with NQS, stakeholders can use nine levers to align their core business or organizational functions to drive improvement on the aims and priorities. Each of the levers represents a core business function, resource, or action that stakeholders can use to align to the NQS: Measurement and Feedback; Public Reporting; Learning and Technical Assistance; Certification, Accreditation, and Regulation; Consumer Incentives and Benefit Designs; Payment; Health Information Technology; Innovation and Diffusion; and Workforce Development.

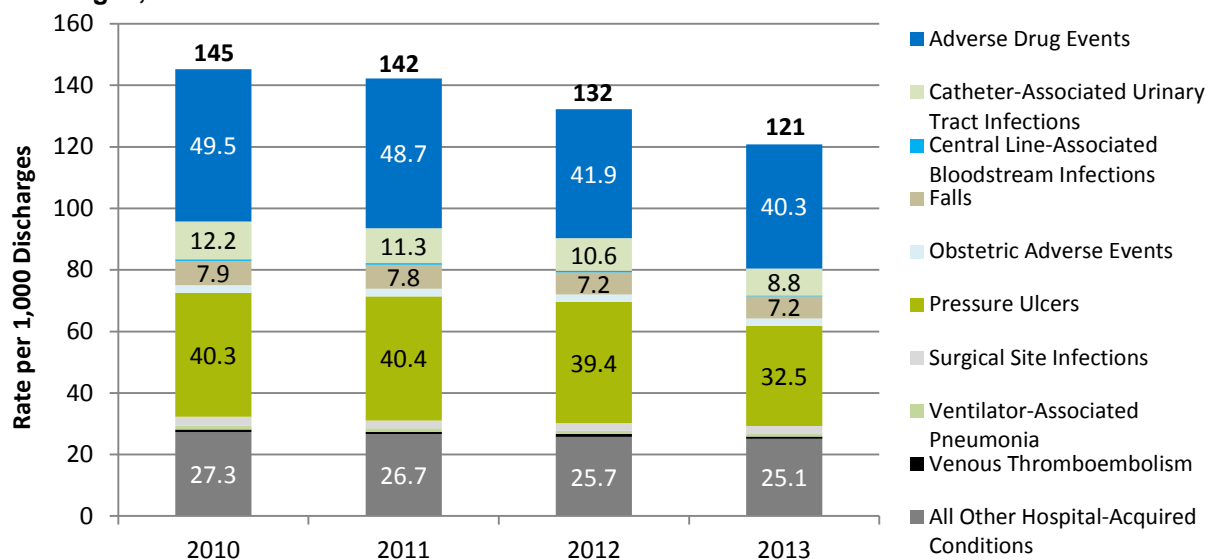
Each year, a progress report is produced. The 2014 NQS progress report (<http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2014annlrpt.htm>) features *Priorities in Action*, which highlights promising and transformative quality improvement programs and spotlights organizations that have adopted the NQS as a framework for quality improvement. To complement this activity, the 2014 QDR begins tracking progress along each of the six NQS priorities.

In this section, an illustrative measure tracked by the QDR is presented for each priority. Information on trends and disparities is also shown for each priority with sufficient data to summarize. Tracking of all QDR measures will be included in a series of statistical chartbooks that will be posted online after the release of the 2014 QDR.

NQS: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare’s Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Distribution of hospital-acquired conditions based on national rates per 1,000 hospital adult discharges, 2010-2013



Source: Agency for Healthcare Research and Quality, Medicare Patient Safety Monitoring System, 2010-2013; Centers for Disease Control and Prevention, National Healthcare Safety Network, 2010-2013; and Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010-2012.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and \$12 billion savings in health care costs.³
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

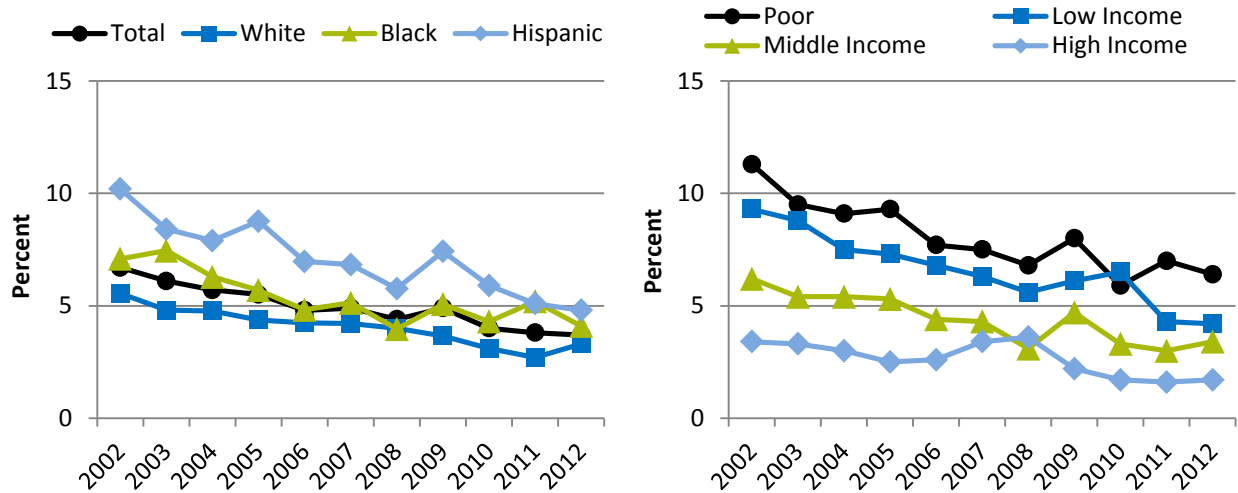
Disparities Trends (Table 1)

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

NQS: Measures of Person-Centered Care improved steadily, especially for children.

Effective and respectful provider-patient communication is at the core of person-centered care. The 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (<http://minorityhealth.hhs.gov>) provides a framework to help organizations deliver services that are responsive to patients' diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Children who had a doctor's office or clinic visit in the last 12 months whose parents reported poor communication with health providers, by race/ethnicity and income, 2002-2012



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.

Note: Parents who report that their child's health providers *sometimes or never* listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial, ethnic, and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

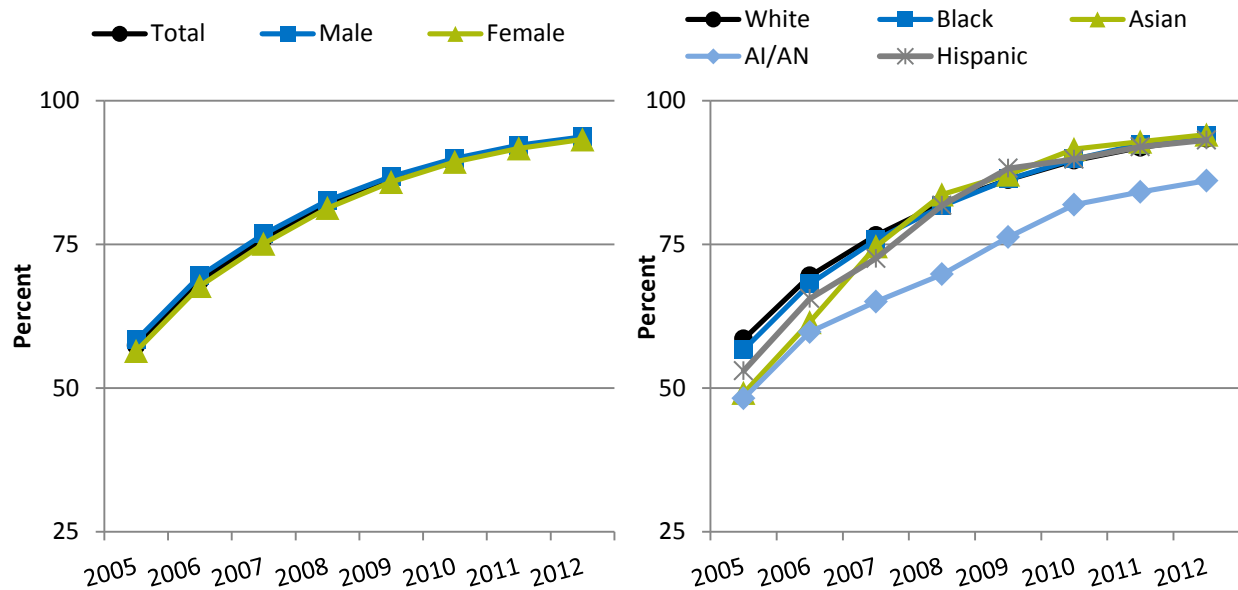
Disparities Trends (Table 1)

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

NQS: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Effective care coordination requires explicit attention to the many settings in which patients receive care as well as the infrastructure to support information exchange across these sites. The Community-based Transitions Program coordinates discharge from hospitals to other care settings and seeks to reduce hospital readmissions. Care coordination also is facilitated by the meaningful use of health information technologies. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 gives HHS the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health information technology, including electronic health records and private and secure electronic health information exchange.

Hospital patients with heart failure who were given complete written discharge instructions, by sex and race/ethnicity, 2005-2012



Source: Centers for Medicare & Medicaid Services, Medicare Quality Improvement Organization Program, 2005-2012.

Note: Measure is labeled “Heart failure patients given discharge instructions” on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

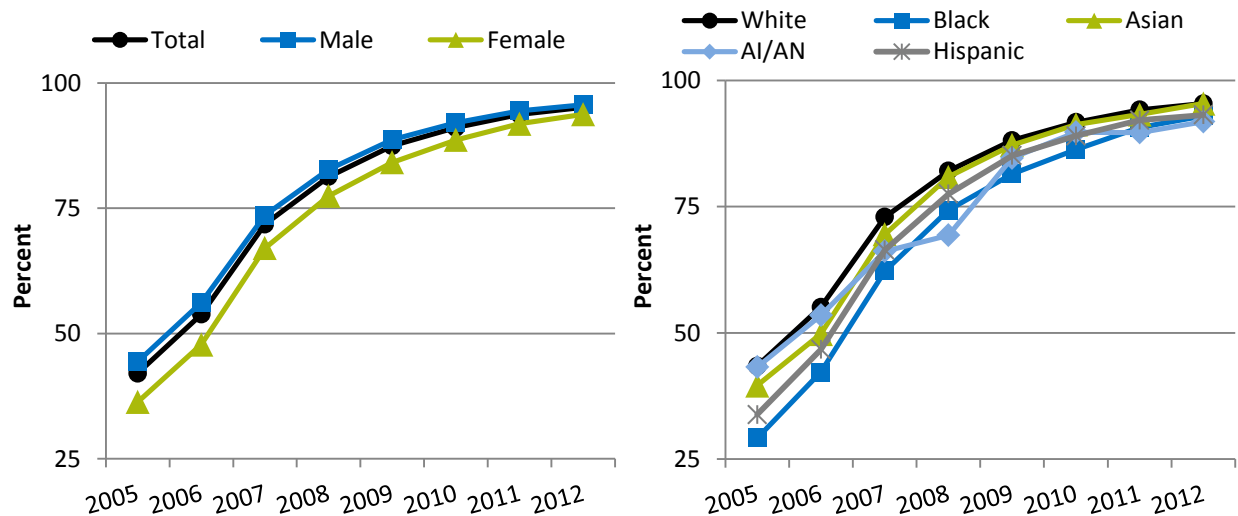
Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

NQS: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

The Centers for Medicare & Medicaid Services began publicly reporting measures of hospital quality on the Hospital Compare website in 2005. CMS Compare websites are now available to assess performance of physicians, nursing homes, home health agencies, and dialysis facilities. Concurrent with public reporting, many CMS measures achieved overall performance levels of 95% or better. At this level, additional improvement is limited, so these measures are no longer reported in the QDR.

Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival, by sex and race/ethnicity, 2005-2012



Source: Centers for Medicare & Medicaid Services, Medicare Quality Improvement Organization Program, 2005-2012.

Note: Measure is labeled “Heart attack patients given PCI within 90 minutes of arrival” on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

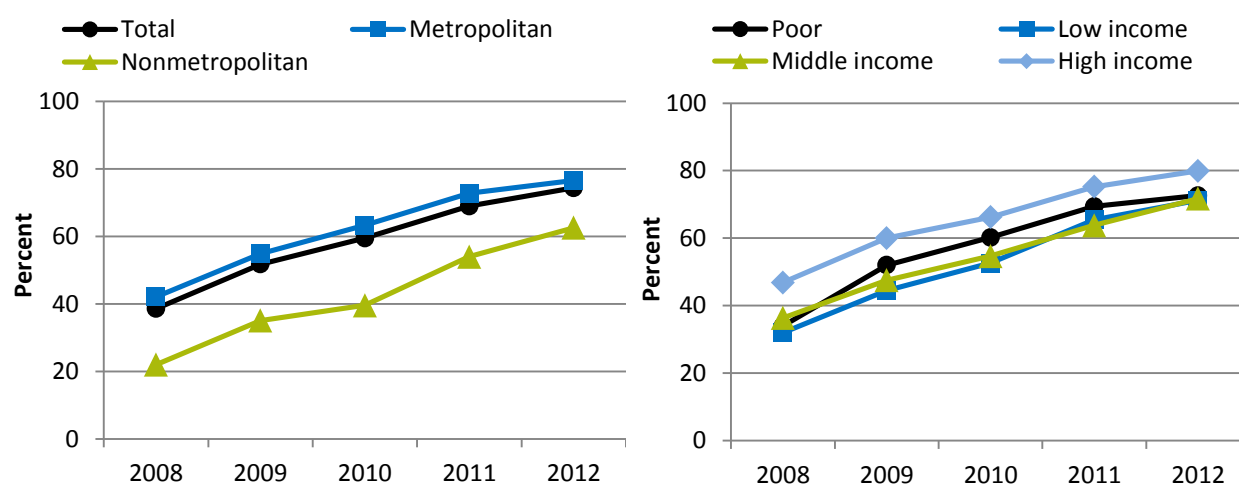
Disparities Trends (Table 1)

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

NQS: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Promoting healthy lifestyles that prevent disease and disability is better for people and more efficient than treating conditions after organ damage has been done.

Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine, by residence location and income, 2008-2012



Source: Centers for Disease Control and Prevention, National Center for Immunizations and Respiratory Diseases and National Center for Health Statistics, National Immunization Survey—Teen, 2008-2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanus-diphtheria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

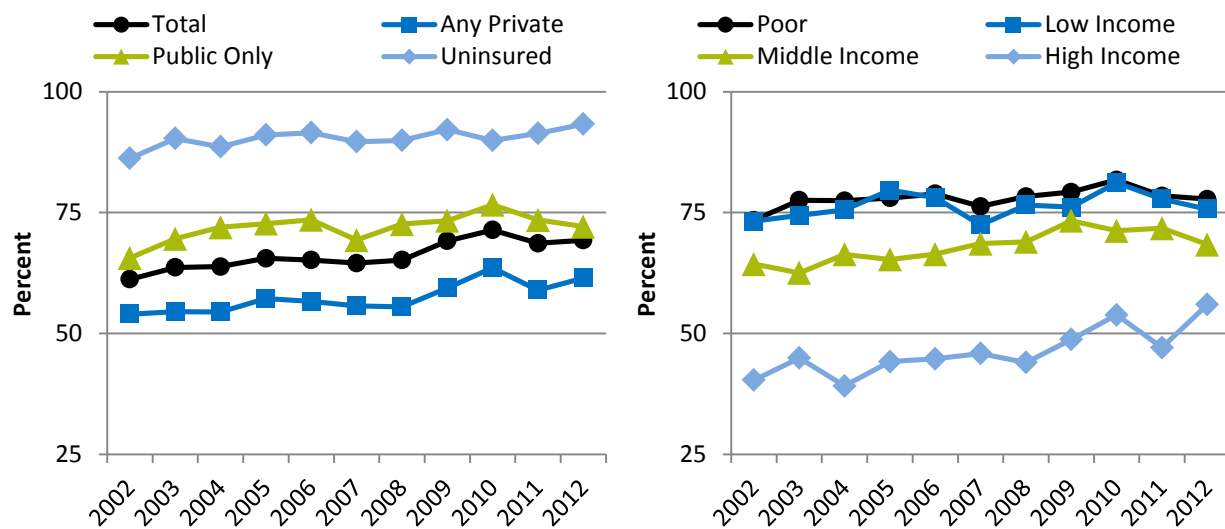
Disparities Trends (Table 1)

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

NQS: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons, by insurance and income, 2002-2012



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.

Trends

- From 2002 to 2010, the overall percentage of people who were unable to get or were delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.⁴
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:
 - Higher among uninsured people and people with public insurance compared with people with any private insurance.
 - Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 QDR demonstrates that access to care improved. After years of stagnation, rates of uninsurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of health care continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded. Efforts by the HHS Measurement Policy Council (<http://www.ahrq.gov/workingforquality/mpcmeasures.pdf>) and the National Quality Forum Measure Applications Partnership (<http://www.qualityforum.org/map/>) are underway to fill these measurement gaps.

Through local quality improvement and patient safety initiatives, providers and communities drive us toward better health care. The 2014 QDR documents the tremendous progress the nation has made toward the goal of high-quality health care that is accessible to all Americans and identifies areas of strength and weakness in the U.S. health care system. Policymakers can use these findings to celebrate the success that has been achieved and to direct future efforts toward making health care more coordinated, affordable, and equitable.

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