U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality
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Improving Diagnosis in Health Care: From Concept to Action

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My Story

- Became Director May 2016
- Primary care physician
- Academic medicine background
  - San Francisco General Hospital
  - U.C. San Francisco Institute for Health Policy Studies
- Questions generated from practice; results used to change local practice

AHRQ's Mission

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

Patient Safety and AHRQ: A Short History

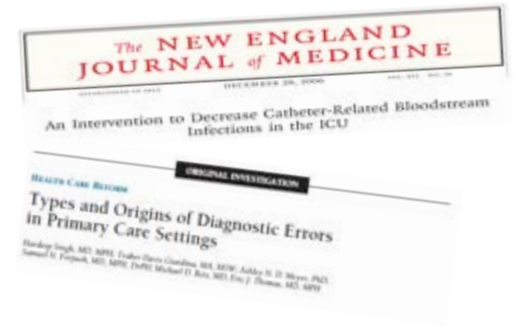
- 1999: AHRQ designated Federal lead in patient safety
- 2000: National Summit on Medical Errors/Patient Safety
- 2001: First patient safety grants awarded

How AHRQ Makes a Difference

- AHRQ **invests in research and evidence** to understand how to make health care safer and improve quality
- AHRQ creates materials to **teach and train** health care systems and professionals to **catalyze** improvements in care
- AHRQ **generates measures and data** used to track and improve performance and evaluate progress of the U.S. health system

AHRQ's Unique Role: Evidence and Implementation

Evidence → Tools for Implementation → Data and Measures



H·CUP
HEALTHCARE COST AND UTILIZATION PROJECT

MEPS

NQMC NATIONAL QUALITY MEASURES CLEARINGHOUSE

Improvements in Patient Safety 2010 - 2014

17% reduction in HACs

87,000 lives saved

2.1 million patient harms avoided

$19.8 billion in savings

Saving Lives and Saving Money: Hospital-Acquired Conditions Update Interim Data From National Efforts To Make Care Safer, 2010-2014:
www.ahrq.gov/news/newsroom/press-releases/2015/saving-lives.html

AHRQ's Patient Safety Budget

What is AHRQ's patient safety budget? (FY'16)

1. <$100 million
2. $100 million to $200 million
3. $200 million to $300 million
4. $400 million to $500 million
5. >$500 million

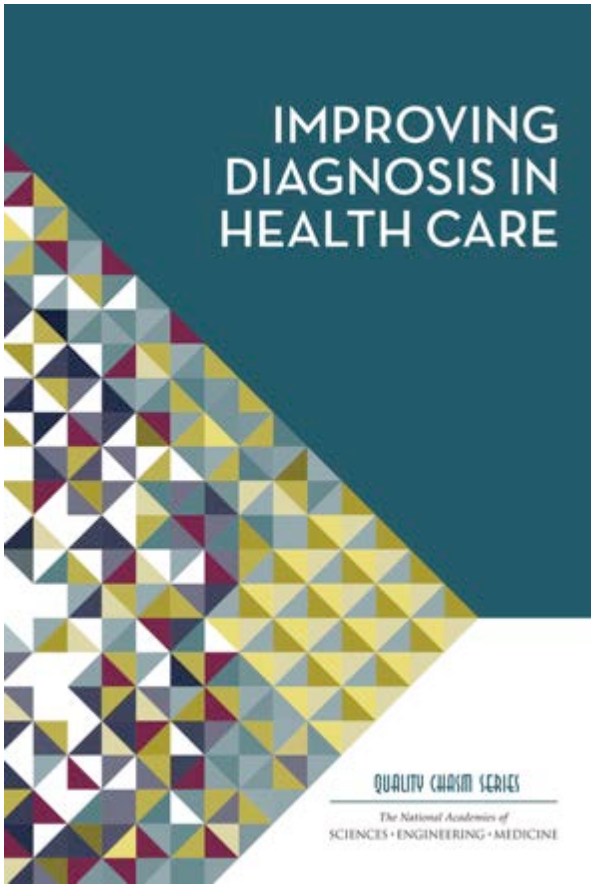
AHRQ's Patient Safety Budget

$76 Million

For one of the major leading causes of death

National Academy of Medicine Report

- Published September 2015
- Part of the Quality Chasm series of reports
- Sponsored in part by AHRQ



www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx

Goals for Today

- Define diagnostic safety and diagnostic error
- Begin to understand how to measure it
- Explore potential solutions
  - Technology
  - Organizational factors
- Commit to a research agenda

Today's Agenda

- Introduction
  - Victor J. Dzau, M.D., National Academy of Medicine
- Overview
  - Jeff Brady, M.D., AHRQ CQuIPS
- Physician and Patient Perspectives
  - Gordon Schiff, M.D., Brigham & Women's Center for Patient Safety Research and Practice
- Milestones
  - Mark Graber, M.D., Society to Improve Diagnosis in Medicine
- Breakout Panels
  - Use of Data and Measurement
  - Health IT's Role
  - Organizational Factors
- Reconvene as a Group to Summarize Panel Discussions and Consider Next Steps

Let’s Work Together