Title
The Agency for Healthcare Research and Quality and the Development of a Learning Health Care System

Permalink
https://escholarship.org/uc/item/8x18x1z4

Journal
JAMA INTERNAL MEDICINE, 177(7)

ISSN
2168-6106

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Publication Date
2017-07-01

DOI
10.1001/jamainternmed.2017.2589

Peer reviewed
The Agency for Healthcare Research and Quality (AHRQ), of which I was the director from May 2016 until January 2017, has played a leading federal role in promoting evidence-based medicine through its support of health services research, the synthesis of clinical research findings into evidence, and strategies to move evidence into practice. Although evidence-based medicine remains an aspirational goal, studies consistently show gaps between optimal care as determined by research evidence and actual practice. In this Viewpoint, I describe a strategy begun during my time at AHRQ that has the potential to be more effective than prior approaches for moving evidence into practice.

AHRQ has regarded the synthesis of research findings on a topic, with rigorous statistical and other scientific techniques to be the highest form of evidence. Thus, the agency has supported the methods and the actual work of doing this by partnering with evidence-based practice centers located at 13, primarily academic, institutions in the United States and Canada, which published 56 evidence reviews on prevention, treatment, and delivery system topics in 2016.

The predecessor of AHRQ, known as the Agency for Health Care Policy and Research (AHCPR), would take the additional step of translating the findings from evidence reviews into practice guidelines. However in some cases, most notably a guideline related to treatment of back pain, a group of clinicians, who perceived that their clinical decision making and autonomy were being threatened by federal practice guidelines, sought to undermine the agency’s role in this work. These clinicians organized a lobbying effort in Congress, which resulted in the renaming of AHCPR as AHRQ, a reduction in the agency’s budget, and the elimination of guideline development as a part of the agency’s functions.

As an alternative to producing clinical guidelines, AHRQ began working with clinical specialty societies to support the implementation of evidence into practice, a role that specialty societies have embraced. These organizations are invited to nominate topics for AHRQ to conduct an evidence review. Once the reviews are completed, the hope is that the specialty societies will use the findings to issue guidance to clinicians. Although AHRQ is not responsible for the development of the guidelines, it maintains the National Guidelines Clearinghouse.

For many clinicians, specialty societies are trusted and influential sources of information on practice. However, there are limitations in relying on them to broker information between investigators and clinicians. Specialty societies are not in a position to understand the wide range of workflow challenges clinicians face in implementing their guidance. Furthermore, specialty societies also lobby on behalf of the financial interests of their members, which can introduce a conflict for interpreting evidence and issuing practice guidance. The contradictions in guidance among specialty societies may contribute to variation in practice even within the same health care system, and thereby undermine patients’ ability to have consistent information with which they can participate in shared decision making.

Given the large gaps in time between the production of new knowledge and its application in practice, the current approach to disseminating evidence to clinicians seems inadequate. Patients can be deprived of information about potentially beneficial treatment approaches, and the lack of a system to counteract differential rates of dissemination among clinicians who care for patients with different social characteristics may contribute to health care disparities.

The rapid consolidation of physicians into health care organizations provides another means for disseminating evidence that could improve the inconsistent results achieved by relying on specialty societies. Motivated in large part by alternative payment models that hold clinicians accountable for cost and quality, these organizations have a need to be consistent in their practices and to develop their capacity to become learning health care systems, which can continually improve care over time.

Learning health care systems adopt evidence on a systematic basis and ensure that it is incorporated into decision making throughout the organization in a consistent way. This can be evidence developed outside or within the organization, such as through the analysis of electronic health data. The goal is not to have all patients with a similar clinical need receive the same treatment, but rather to ensure that patients receive consistent information regardless of their clinician or the specific location of care. Patients require consistent information to engage in shared decision making.

The path to becoming a learning health care system is unchartered territory for most health care organizations. If they are to succeed, they will need help in developing processes for adopting, generating, and applying evidence. Because AHRQ is neither a payer nor a regulator, it is the federal agency best positioned to serve as a facilitator that can help health care organizations to make this transition. AHRQ has relevant experience in establishing the scientific methods health care organizations can use to judge the quality of evidence they generate from their own data or that they wish to adopt from external research. AHRQ has also had success in build-
The health care system in the United States is rapidly undergoing changes in how clinicians are paid, organized, and connected through information technology. These changes are providing incentives and opportunities to achieve higher value from our health care investments. This will require substantial investment by health care organizations and long-range planning without a definitive roadmap for how to achieve success. With enhanced resources and visibility, AHRQ is uniquely qualified and positioned to assist in this journey and to provide a public benefit that the marketplace has yet to deliver on its own.

ARTICLE INFORMATION

Conflict of Interest Disclosures: None reported.

Disclaimer: Dr Bindman served as the director of AHRQ from May 2, 2016, until January 20, 2017. The opinions reflected in this article are solely those of the author and do not necessarily represent the views of AHRQ or the Department of Health and Human Services.

REFERENCES