

2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy



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**2015 NATIONAL HEALTHCARE
QUALITY AND DISPARITIES REPORT
and
5th ANNIVERSARY UPDATE ON THE
NATIONAL QUALITY STRATEGY**

**U.S. DEPARTMENT OF
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EXECUTIVE SUMMARY

This year's *National Healthcare Quality and Disparities Report* and *National Quality Strategy Update* have been integrated into this single document that describes the nation's progress in improving health care access, quality, and disparities.

Key findings from this year's report include:

- **Access** to health care has improved dramatically, led by sustained reductions in the number of Americans without health insurance and increases in the number of Americans with a usual source of medical care.
- **Quality** of health care continues to improve, but wide variation exists across the National Quality Strategy priorities.
 - **Effective Treatment** measures indicate success at both improving overall performance and reducing disparities.
 - **Care Coordination** measures have lagged behind other priorities in overall performance.
 - **Patient Safety, Person-Centered Care, and Healthy Living** measures have improved overall but few disparities have been reduced.
 - **Care Affordability** measures are limited for summarizing performance and disparities.
- **Disparities** related to race and socioeconomic status persist among measures of access and all National Quality Strategy priorities, but progress is being made in some areas. Disparities in quality of care and disparities in access to care typically follow the same pattern, although disparities in access tend to be more common than disparities in quality

As health care delivery continues to evolve, the framework of the National Quality Strategy and the tracking of the National Healthcare Quality and Disparities Report can help identify system successes that should be celebrated as well as aspects of the system that require attention. While most measures of health care quality can only be tracked through 2013 and therefore are insufficient for assessing trends following the major coverage expansions of the Affordable Care Act, these reports establish the baseline against which to track progress in future years.

Integration Statement

For the first time, this year's *National Healthcare Quality and Disparities Report* and *National Quality Strategy Update* is a joint effort addressing the progress made against the National Quality Strategy priorities at the 5-year anniversary of the Strategy. The National Quality Strategy is backed by the *National Healthcare Quality and Disparities Report* data. Integration of these two efforts within the Agency for Healthcare Research and Quality (AHRQ) supports the development of this more comprehensive report on the success of efforts to achieve better health and health care and reduce disparities.

About the National Healthcare Quality and Disparities Report

For the 13th year in a row, AHRQ has reported on health care quality and disparities. The annual *National Healthcare Quality and Disparities Report* (QDR) provides 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 report measures trends in several dimensions of quality, including effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. On a rolling basis, the report presents, in a chart form referred to as “Chartbooks,” the latest available findings on quality of and access to health care as they become available.

The report assesses the performance of our health care system and identifies areas of strengths and weaknesses, as well as disparities, along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy. The report is based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. The reports are produced with the help of an Interagency Workgroup led by AHRQ.

About the National Quality Strategy

The Patient Protection and Affordable Care Act mandated the establishment of a National Strategy for Quality Improvement in Health Care (the National Quality Strategy, or NQS), as part of the goal of increasing access to high-quality, affordable health care for all Americans. The National Quality Strategy pursues three broad aims (better care, healthy people/healthy communities, and affordable care), supported by six priorities (making care safer; person- and family-centered care; effective communication and care coordination; prevention and treatment of leading causes of morbidity and mortality; health and well-being of communities; and making quality care more affordable). The National Quality Strategy is foundational for the U.S. Department of Health and Human Services’ broader efforts to help move the health care system to one that achieves the goals of better care, smarter spending, and healthier people.

This year marks the 5-year anniversary of the National Quality Strategy, which was developed through a transparent and collaborative process with input from a range of stakeholders, representing all sectors of the health care industry and the general public. The National Quality Strategy serves as a guide for identifying and prioritizing quality improvement efforts, sharing lessons learned, and measuring the collective success of Federal, State, and private-sector health care stakeholders across the country.

Five years later, diverse stakeholders, including federal agencies, community health organizations, and commercial companies are working together in new and innovative ways to make the National Quality Strategy part of their day-to-day efforts to make health and health care better and more affordable for people and communities. At the federal level, the Strategy’s aims (better care, healthy people/healthy communities, and affordable care) and six priorities (making care safer; person- and family-centered care; effective communication and care coordination; prevention and treatment of leading causes of morbidity and mortality; health and well-being of communities; and making quality care more affordable) have paved the way for the U.S. Department of Health and Human Services’ operating divisions, along with the U.S. Office of Personnel Management, to incorporate the Strategy into their quality improvement activities.

Rationale for Integration

In the 5 years since the National Quality Strategy was released, health care in America has undergone many changes. As a result of the Affordable Care Act, 20 million adult Americans have obtained health insurance from 2011 to 2016, including 8.9 million White, 4 million Hispanic, and 3 million Black adults ages 18-64 from the start of open enrollment in October 2013 through early 2016.¹

As more Americans continue to obtain health insurance and use health care services, achievement of the National Quality Strategy aims of better, more affordable care for individuals and the community increasingly demands a focus on maintaining increased access to care and reducing health disparities that lead to unequal health outcomes. In this dynamic health care environment, the National Quality Strategy and *National Healthcare Quality and Disparities Report* play complementary roles in improving health and health care quality for all Americans.

The National Quality Strategy highlights progress made on the Strategy's six priorities and notes which priorities show significant improvements and which merit more attention. The annual *National Healthcare Quality and Disparities Report* was designed specifically to detect changes in health care access, quality, and disparities and can track progress made for each of the National Quality Strategy priorities.

Organization of Integrated Report

This integrated report presents information on trends, disparities, changes in disparities over time, and initiatives across the country demonstrating innovative quality improvement programs. The following sections are:

- **Aims of the National Quality Strategy** that describes quality improvement goals for the Nation.
- **Access and Disparities in Access to Health Care** that tracks progress on making health care available to all Americans.
- **Quality and Disparities in Quality of Health Care** that tracks progress on ensuring that all Americans receive appropriate, safe, timely, and person-centered services.
- **Priorities of the National Quality Strategy** that tracks progress on each priority and identifies promising practices for each priority.
- **Looking Forward** that summarizes future directions for health care quality initiatives.



AIMS OF THE NATIONAL QUALITY STRATEGY

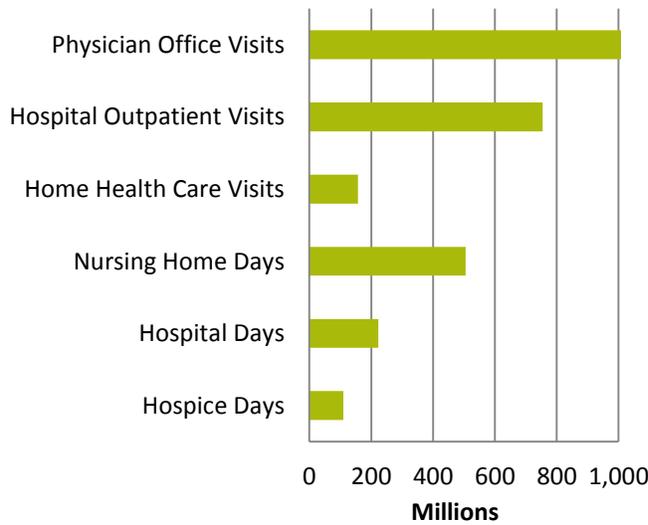
The National Quality Strategy pursues three broad aims that guide local, state, and national efforts to improve population health and the health care delivery system. The National Quality Strategy's three aims closely resemble the Institute for Healthcare Improvement (IHI) Triple Aim[®] and build on the work that IHI has done by giving additional consideration to the health of communities at different levels and affordability for multiple groups. The three aims are:

1. **Better Care:** Improve overall quality, by making health care more patient centered, reliable, accessible, safe, and focused on achieving meaningful health outcomes.
2. **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.
3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

The health care system is highly complex. The scope of the challenge to achieve these three aims is illustrated in the figures in this section. Progress toward these aims is discussed in the sections that follow. Millions of health care workers in a variety of settings deliver billions of services each year. People experience mortality and morbidity from myriad ailments, necessitating the availability of specialized training, treatment, and technology. Trillions of dollars are spent each year on personal health care from a variety of public and private sources. An effective National Quality Strategy is needed to help coordinate stakeholders in support of the system as a whole.

AIM 1: Achieving Better Care requires coordinating services across a complex health care system. Health care employs millions of workers providing billions of services each year. Improving care requires facilities and providers to work together to expand access, enhance quality, and reduce disparities. Care delivered by providers in many types of health care settings is tracked in the QDR. While health is affected by many factors besides health care, receipt of appropriate high-quality services and counseling about healthy lifestyles can facilitate the maintenance of well-being and functioning.

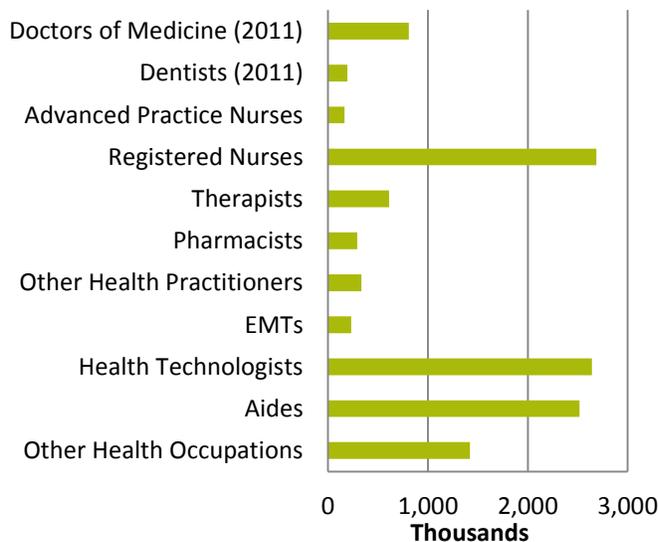
Numbers of Health Care Services, U.S., 2011



- In 2011, there were 1 billion physician office visits (including visits to physicians in health centers), 754 million hospital outpatient visits, and 157 million home health visits.
- Patients spent 506 million days in nursing homes, 223 million days in hospitals, and 110 million days under hospice care.

Source: NCHS, *Health, United States, 2014* (physician and hospital); NCHS, Long-term care services in the United States: 2013 overview (nursing home); MedPAC, June 2015 Data Book: health care spending and the Medicare Program (home health and hospice).

Numbers of People Working in Health Occupations, U.S., 2014



- In 2011, there were 810,000 doctors of medicine and 190,000 dentists working in the United States.
- They were joined by 2.7 million registered nurses, 2.6 million health technologists, and 2.5 million nursing and other aides in providing health care in 2014.

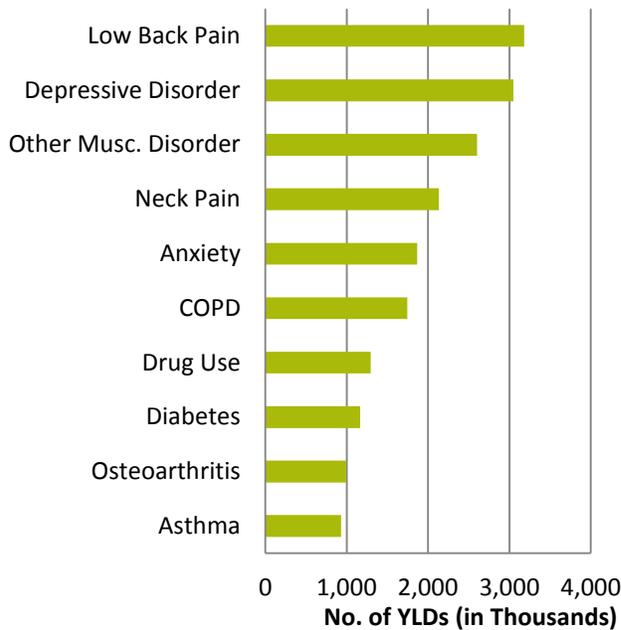
Key: EMT = emergency medical technicians and paramedics.

Source: NCHS, *Health, United States, 2014* (doctors and dentists); and Bureau of Labor Statistics Occupational Employment Statistics, 2014 (all other occupations).

Note: Doctors of Medicine do not include Doctors of Osteopathic Medicine. Aides include nursing, psychiatric, home health, occupational therapy, and physical therapy assistants and aides.

AIM 2: Achieving Healthy People/Healthy Communities requires optimizing population health by mitigating the effects of the leading causes of morbidity and mortality. Care for most of these conditions is tracked in the QDR. Variation in care across communities contributes to disparities related to race, ethnicity, and socioeconomic status.

Leading Diseases Contributing to Years Lived With Disability (YLD), 2010

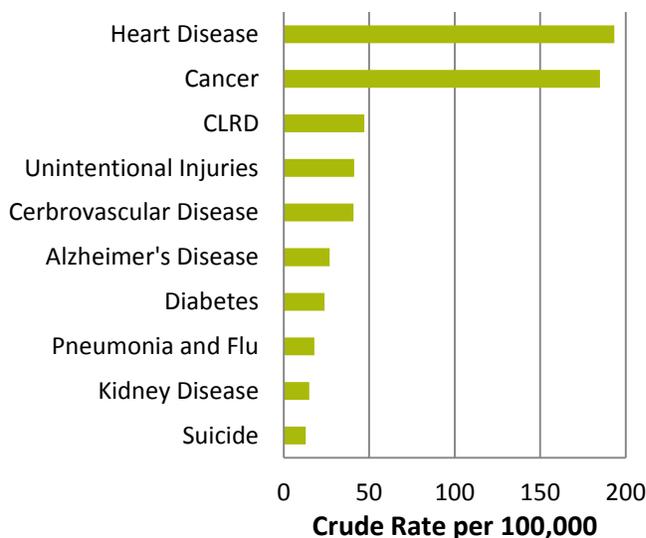


- The eight leading diseases and injuries contributing to YLDs (low back pain, major depressive disorder, other musculoskeletal disorders, neck pain, anxiety disorders, chronic obstructive pulmonary disease, drug use disorders and diabetes) did not change between 1990 and 2010.
- From 1990 to 2010, there was a 56% increase in YLDs caused by osteoarthritis, moving its rank from number 12 to number 9.
- From 1990 to 2010, YLDs caused by asthma only increased 21%, resulting in asthma moving down the ranking from number 9 to number 10.

Key: COPD = chronic obstructive pulmonary disease.

Source: The state of U.S. health, 1990-2010. Burden of diseases, injuries, and risk factors. U.S. Burden of Disease Collaborators. JAMA 2013;310(6):591-608. <http://jama.jamanetwork.com/article.aspx?articleid=1710486>.

Leading Cause of Death, 2013



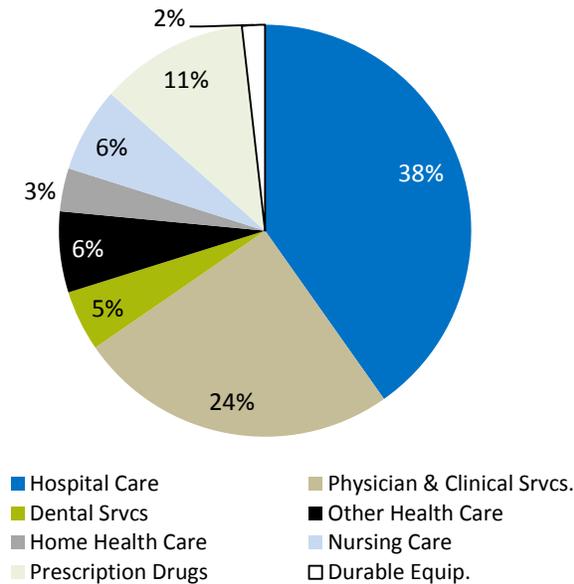
- Heart disease, cancer, chronic lower respiratory diseases, unintentional injuries, cerebrovascular diseases and diabetes were among the leading causes of death for all racial/ethnic groups.
- The leading causes of death vary by race and ethnicity. For example, suicide was not a leading cause of death for Blacks and Hispanics, and Alzheimer's disease was not a leading cause of death for American Indians and Alaska Natives.

Key: CLRD = chronic lower respiratory diseases.

Source: Xu J, Murphy SL, Kochanek KD, et al. Deaths: final data for 2013. Natl Vital Stat Rep 2016; 64(2). http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf.

AIM 3: Achieving Affordable Care requires smarter spending of limited health care dollars. Health care is costly. Multiple sources of fragmented expenditures channeled to the various sectors of care is a challenge for controlling growth in health care costs. New delivery system models that coordinate care across sectors and that may help ensure that money is spent efficiently are highlighted in the QDR.

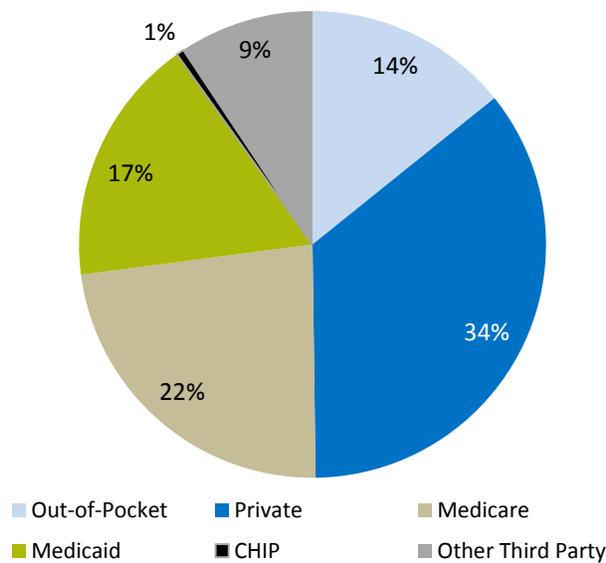
Personal Health Care Expenditures, by Type of Expenditure, 2013



- In 2013, hospital care expenditures were \$936.9 billion, 38% of personal health care expenditures.
- Expenditures for physician and clinical services were \$565.3 billion while expenditures for dental services were \$111.0 billion, 24% and 5% of personal health care expenditures, respectively.
- Prescription drug expenditures were \$271.1 billion, 11% of personal health care expenditures.
- Nursing care facility expenditures were \$155.8 billion and home health care expenditures were \$79.8 billion, or 6% and 3% of personal health care expenditures, respectively.

Source: CMS, National Health Expenditures Account, as reported in NCHS, *Health, United States, 2014*.

Personal Health Care Expenditures, by Source of Funds and Type of Expenditure, 2013



- In 2013, private insurance covered 34% of personal health care expenditures, followed by Medicare, Medicaid, and out of pocket.
- Sources of funds varied by type of expenditure.
- Private insurance was responsible for 37% of hospital, 46% of physician, 7% of home health, 8% of nursing home and 44% of prescription drug expenditures.
- Medicare was responsible for 26% of hospital, 22% of physician, 43% of home health, 22% of nursing home and 28% of prescription drug expenditures.
- Medicaid was responsible for 18% of hospital, 9% of physician, 37% of home health, 30% of nursing home and 8% of prescription drug expenditures.
- Out-of-pocket payments covered 4% of hospital, 9% of physician, 8% of home health, 29% of nursing home, and 17% of prescription drug expenditures.

Source: CMS, National Health Expenditures Account, as reported in NCHS, *Health, United States, 2014*.

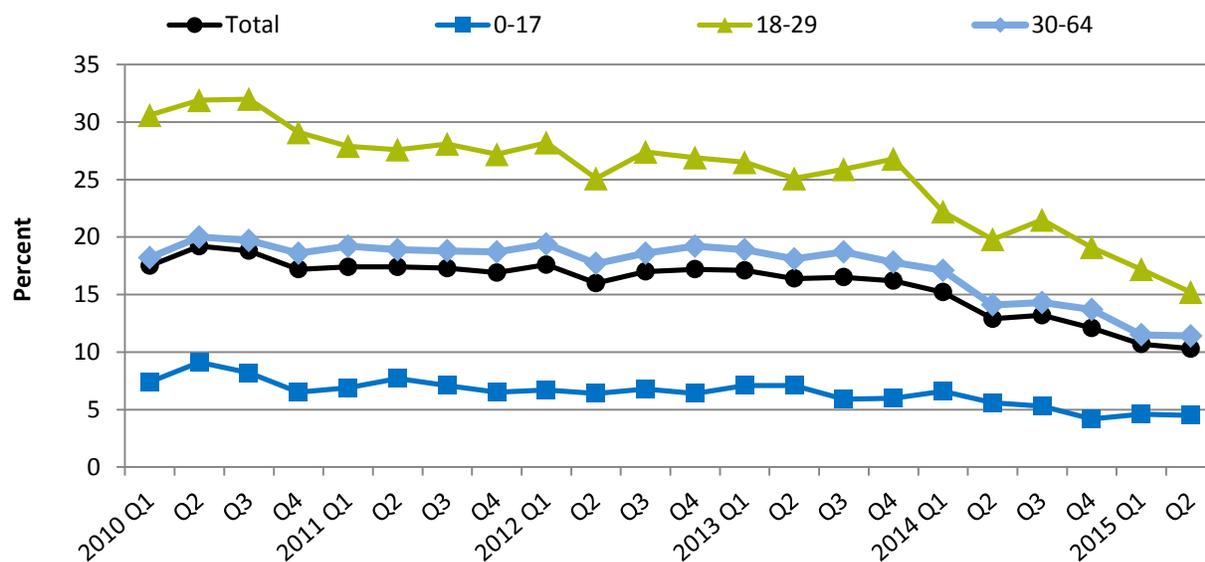
ACCESS AND DISPARITIES IN ACCESS TO HEALTH CARE

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, gender identity, and residential location.

The Affordable Care Act was 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.

After years without improvement, **Access to Care has improved in a number of important areas since 2010.**

People under age 65 who were uninsured at the time of interview, by age, 2010-2015 Q2



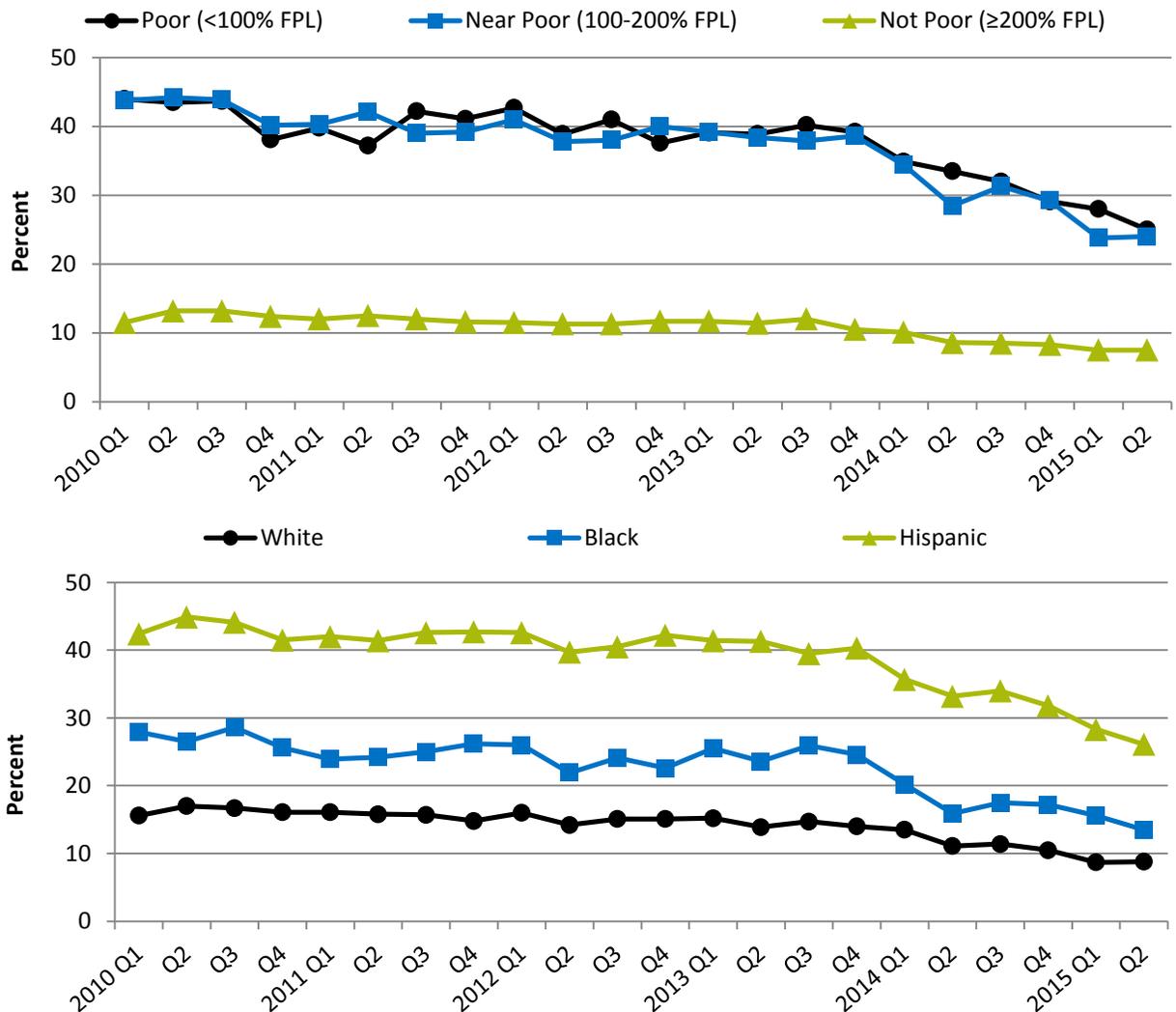
Key: Q = quarter.

Source: Cohen RA, Martinez ME. Health insurance coverage: early release of quarterly estimates from the National Health Interview Survey, January-June 2015. Hyattsville, MD: National Center for Health Statistics; November 2015. http://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_estimates_2010_2015_Q12.pdf

- From 2010 to the second quarter of 2015, the percentage of people under age 65 who were uninsured at the time of interview decreased from 17.5% to 10.3%.
- The percentage of people who were uninsured at the time of interview decreased for all age groups under age 65. Adults ages 18-29 experienced the largest declines in uninsurance.

In addition, while still present, some **Access Disparities** have been getting smaller since 2010. For example, **disparities in health insurance have narrowed.**

People ages 18-64 who were uninsured at the time of interview, by poverty status (top) and race/ethnicity (bottom), 2010-2015 Q2



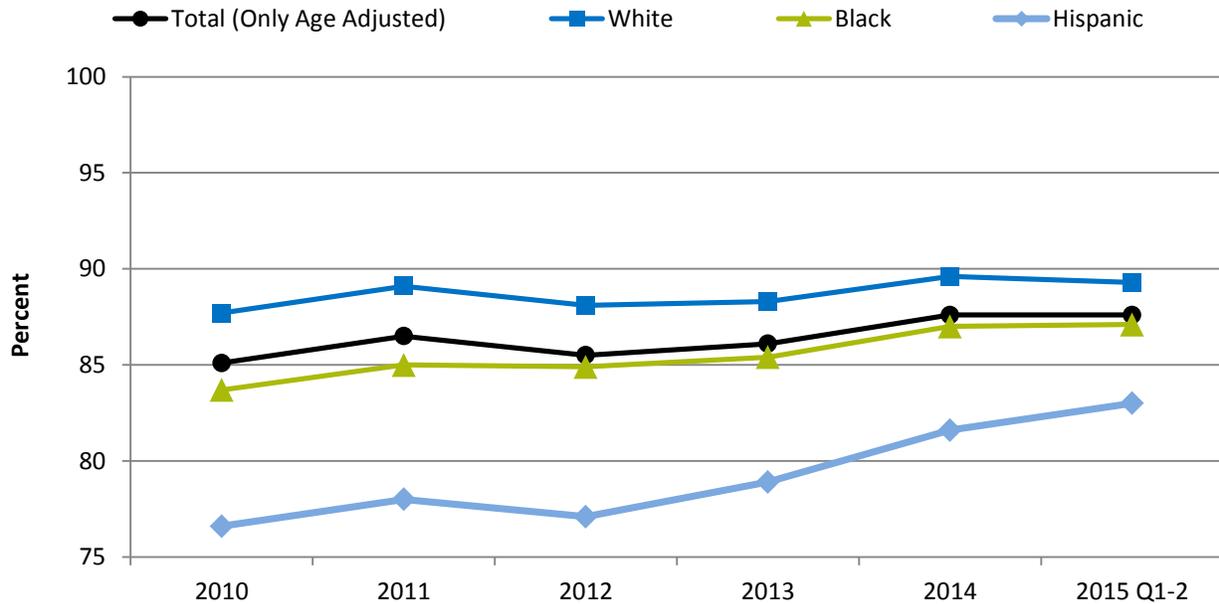
Key: Q = quarter. FPL = federal poverty level.

Source: Cohen RA, Martinez ME. Health insurance coverage: early release of quarterly estimates from the National Health Interview Survey, January-June 2015. Hyattsville, MD: National Center for Health Statistics; November 2015. http://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_estimates_2010_2015_Q12.pdf

- From 2010 to the second quarter of 2015, among adults ages 18-64 years, the percentages who were uninsured at the time of interview decreased for all poverty status and racial/ethnic groups.
- People in poor and near-poor households were more likely to be uninsured than people in households that were not poor. Poor-not poor and near poor-not poor gaps in uninsurance decreased over the 2010-2015 period.
- Blacks and Hispanics were more likely to be uninsured than Whites. Black-White and Hispanic-White gaps in uninsurance decreased over the 2010-2015 period.

Disparities in having a usual place to go for medical care, a measure of realized access, have also narrowed.

Age-sex adjusted percentage of people of all ages with a usual place to go for medical care, by race/ethnicity, 2010-2015 Q1-2



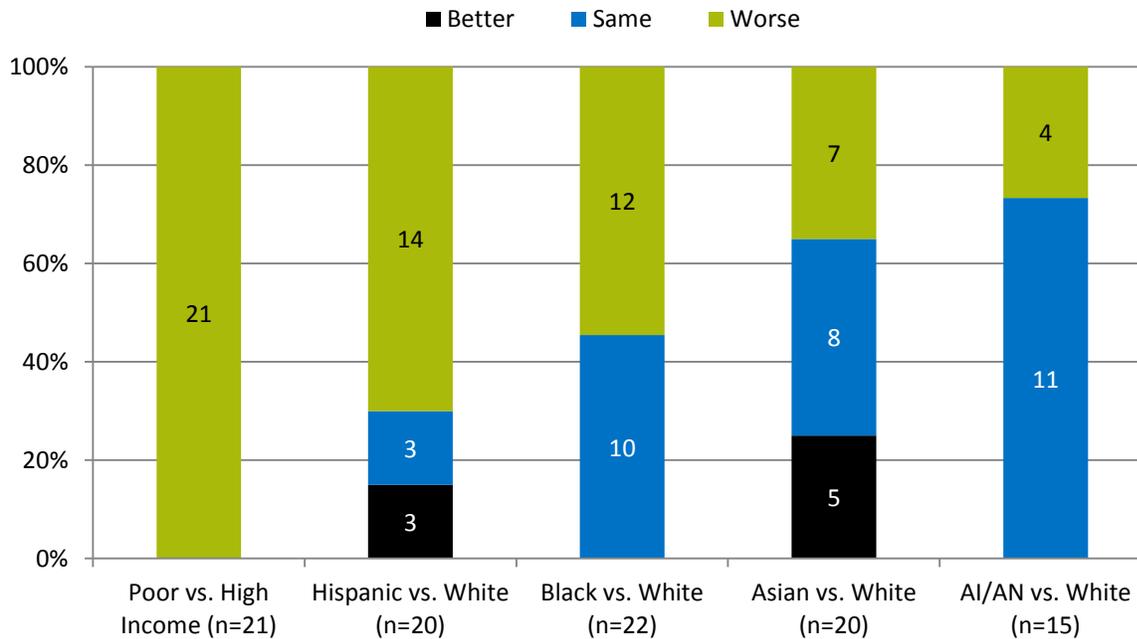
Source: Ward BW, Schiller JS, Freeman G, and Clarke TC. Early release of selected estimates based on data from the January-June 2015 National Health Interview Survey. Hyattsville, MD: National Center for Health Statistics; November 2015. <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201511.pdf>. Estimates prior to 2015 may be found in earlier Early Release reports.

Note: Data only available for 2015 quarters 1 and 2.

- From 2010 to the first half of 2015, the percentage of people with a usual place to go for medical care increased overall, for Blacks, and for Hispanics, but not for Whites.
- In all years, Blacks and Hispanics were less likely than Whites to have a usual place to go for medical care.
- Gaps related to race/ethnicity were narrowing over time.

Despite improvements, **Access Disparities persisted** through 2013, especially among people in poor households, Hispanics, and Blacks.

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



Key: AI/AN = American Indian or Alaska Native; n = number of measures.
Note: Numbers of measures differ across groups because of sample size limitations. The relative difference between a selected group and its reference group is used to assess disparities. For income, the reference group is High Income. For race and ethnicity, the reference group is White.

- **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 20 access measures, similar access on 3 measures, and better access on 3 measures.

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

ⁱ Throughout this report, poor indicates family income less than the federal poverty level, and high income indicates family income four times the federal poverty level or greater. In 2013, the federal poverty level for a family of four living in the continental United States was \$23,550.

QUALITY AND DISPARITIES IN QUALITY OF HEALTH CARE

Measures of health care quality tracked in the QDR encompass a broad array of services, including prevention, emergency treatment, behavioral health care, and chronic disease management; and settings, including doctors' offices, health centers, emergency departments, dialysis centers, hospitals, mental health and substance use treatment facilities, 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. Most data are reported annually and are generally available through 2013. Sources used to assess health care quality in the reports include:

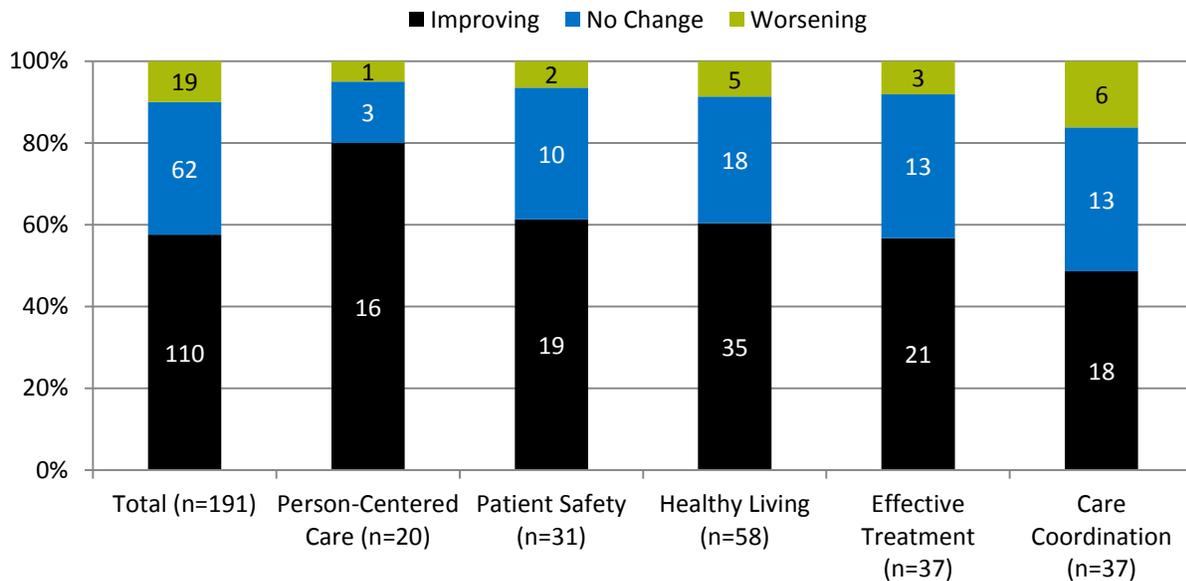
- Surveys of patients, patients' families, and providers;
- Administrative data from health care facilities and home health agencies;
- Abstracts of clinical charts;
- Registry data; and
- Vital statistics.

Historically, quality of health care has varied based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. As specified in the Healthcare Research and Quality Act in 1999, this summary focuses on disparities related to race and socioeconomic status.

With the passage of the Affordable Care Act in 2010, the Department of Health and Human Services (HHS) was charged with identifying national priorities and developing and implementing a National Quality Strategy to achieve better care, healthy people/healthy communities, and affordable care. This section presents summary data across the six National Quality Strategy priorities that address the most common health concerns that Americans face. The following section provides more detail about each National Quality Strategy priority.

Quality of health care improved generally through 2013, but the pace of improvement varied by the NQS priority.

Number and percentage of all quality measures that are improving, not changing, or worsening through 2013, overall and by NQS priority



Key: n = number of measures.

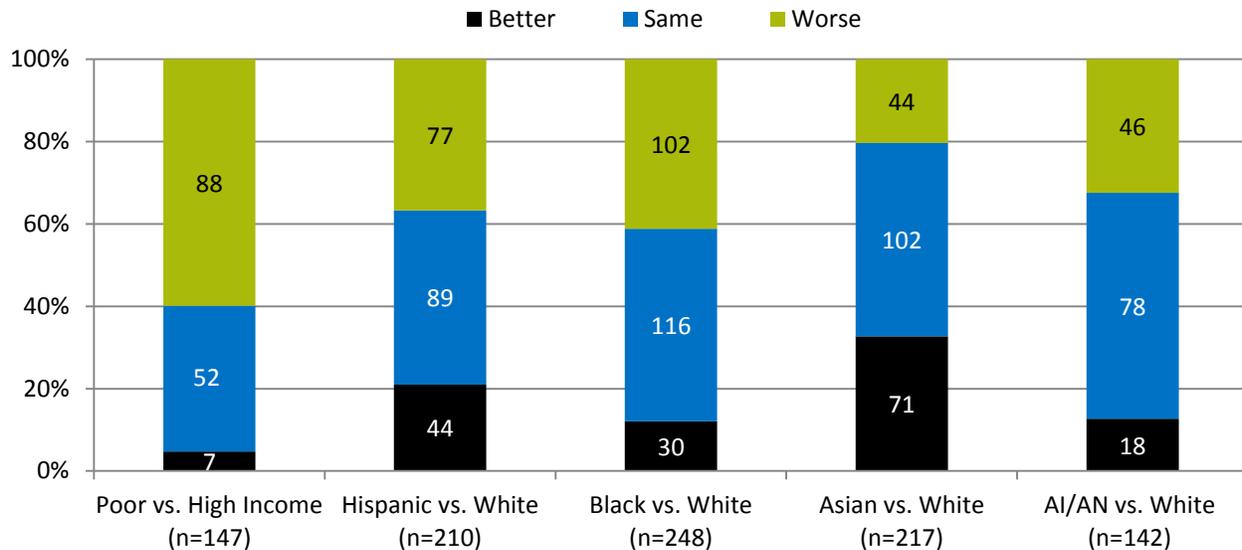
Note: For the majority of measures, trend data are available from 2001 to 2013. Measures of Care Affordability are included in the Total but not shown separately.

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

- **Improving** = Rates of change are positive at 1% per year or greater and are statistically significant.
 - **No Change** = Rates of change are less than 1% per year or not statistically significant.
 - **Worsening** = Rates of change are negative at -1% per year or greater and are statistically significant.
- Through 2013, across a broad spectrum of measures of health care quality, 60% showed improvement.
 - About 80% of measures of **Person-Centered Care** improved.
 - About 60% of measures of **Effective Treatment, Healthy Living, and Patient Safety** improved.
 - Fewer than half of measures of **Care Coordination** improved.
 - Fewer than a dozen measures of **Care Affordability** are tracked in the report, too few to summarize in this way.

Quality Disparities persist, especially among people in poor households, Hispanics, and Blacks.

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



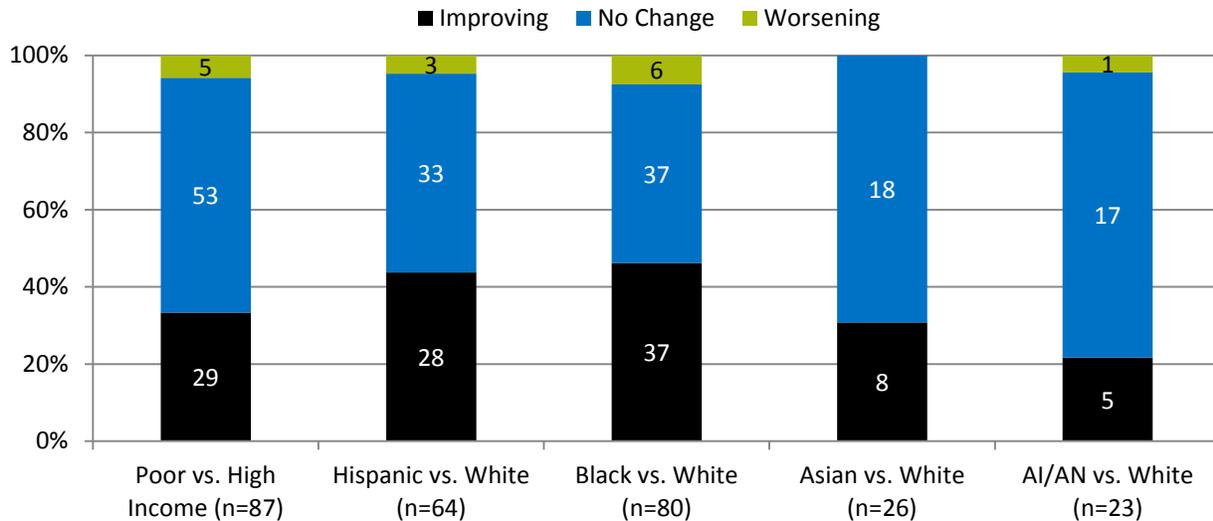
Key: AI/AN = American Indian or Alaska Native; n = number of measures.

Note: Numbers of measures differ across groups because of sample size limitations. The relative difference between a selected group and its reference group is used to assess disparities. For income, the reference group is High Income. For race and ethnicity, the reference group is White.

- **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.
- People in poor households received worse care than people in high-income households for about 60% of quality measures (green).
 - Blacks, Hispanics, and American Indians and Alaska Natives received worse care than Whites for about 40% of quality measures.
 - Asians received worse care than Whites for about 20% of quality measures.
 - For each group, disparities in quality of care are similar to disparities in access to care, although disparities in access tend to be more common than disparities in quality.
 - Disparities also varied across NQS priorities.
 - Disparities were more common among measures of **Person Centered Care** and **Care Coordination**, involving about 60% of comparisons (data not shown).
 - Disparities were less common among measures of **Patient Safety**, **Effective Treatment**, and **Healthy Living**, involving about 30% of comparisons (data not shown).

Some Quality Disparities are getting smaller, but many are not improving across a broad spectrum of quality measures.

Number and percentage of quality measures with disparity at baseline for which disparities related to race, ethnicity, and income were improving, not changing, or worsening through 2013



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

Note: Numbers of measures differ across groups because of sample size limitations. For the majority of measures, trend data are available from 2001 to 2013. For each measure with a disparity at baseline in which the group of interest received worse care than the reference group, average annual percentage changes were calculated for select populations and reference groups. For income, the reference group is High income. For race and ethnicity, the reference group is White. Measures are aligned so that positive rates indicate improvement in care. Differences in rates between groups were used to assess trends in disparities. Measures with no disparity at baseline are excluded.

- **Worsening** = Disparities are getting larger. Differences in rates between groups are statistically significant and rates for the reference group exceed rates for the groups of interest 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 rates for the groups of interest exceed rates for the reference group by at least 1% per year.
- Through 2013, about 40% of disparities at baseline for Blacks, Hispanics, Asians, and people in poor households were getting smaller.
- About 20% of disparities at baseline for American Indians and Alaska Natives were getting smaller.
- Disparities that were getting smaller included 24 measures in which a disparity at baseline was eliminated (9% of disparities at baseline), primarily affecting Blacks and Hispanics.
- There were also 16 measures in which a disparity was not present at baseline but developed over time (4% of contrasts in which there was not a disparity at baseline), primarily affecting Asians (data not shown).
- Change in disparities over time also varied across NQS priorities.
 - About 45% of disparities related to **Care Coordination** and **Effective Treatment** were getting smaller (data not shown).
 - Only about 30% of disparities related to **Patient Safety**, **Person Centered Care**, and **Healthy Living** were getting smaller (data not shown).

PRIORITIES OF THE NATIONAL QUALITY STRATEGY

The National Quality Strategy's **six priorities** address the range of quality concerns that affect most Americans: making care safer by reducing harm caused in the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

In this section, progress on each priority is assessed. Data from the *National Healthcare Quality and Disparities Report* are examined to assess trends, disparities, and changes in disparities over time. National Quality Strategy Priorities in Action are presented and feature some of the nation's most promising and transformative quality improvement programs. These programs represent private sector, federal, state, and local efforts.

Priority 1



Patient Safety: *Making care safer by reducing harm caused in the delivery of care*

The National Quality Strategy calls on all stakeholders to promote patient safety. Although health care providers continue to work toward a delivery system focused on high-quality care, hospital-acquired conditions and harmful complications acquired from ambulatory health care delivery remain common. Prevention of medical errors saves lives and lowers costs, goals shared by all stakeholders across the system and a key to achieving the three aims of the National Quality Strategy.

Patient Safety improved substantially, led by a **17%** reduction in hospital-acquired conditions between 2010 and 2014. Hospital-acquired conditions have been targeted for improvement by the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans and aligned to the National Quality Strategy. Hospital-acquired conditions have also been targeted by AHRQ, which has funded research to demonstrate how care can be made safer, development of tools and training materials to make sure that the research results are understood and used, and development of measures to determine the level of adverse events in hospitals.

A number of public and private efforts, as well as the dedication of practitioners, have contributed to improvement in about 60% of safety measures. These efforts include Medicare's Quality Improvement Organizations, built around the National Quality Strategy's priorities, and HHS' National Action Plan to Prevent Health Care-Associated Infections.

Patient Safety: Distribution of hospital-acquired conditions based on national rates per 1,000 hospital adult discharges, 2010-2014



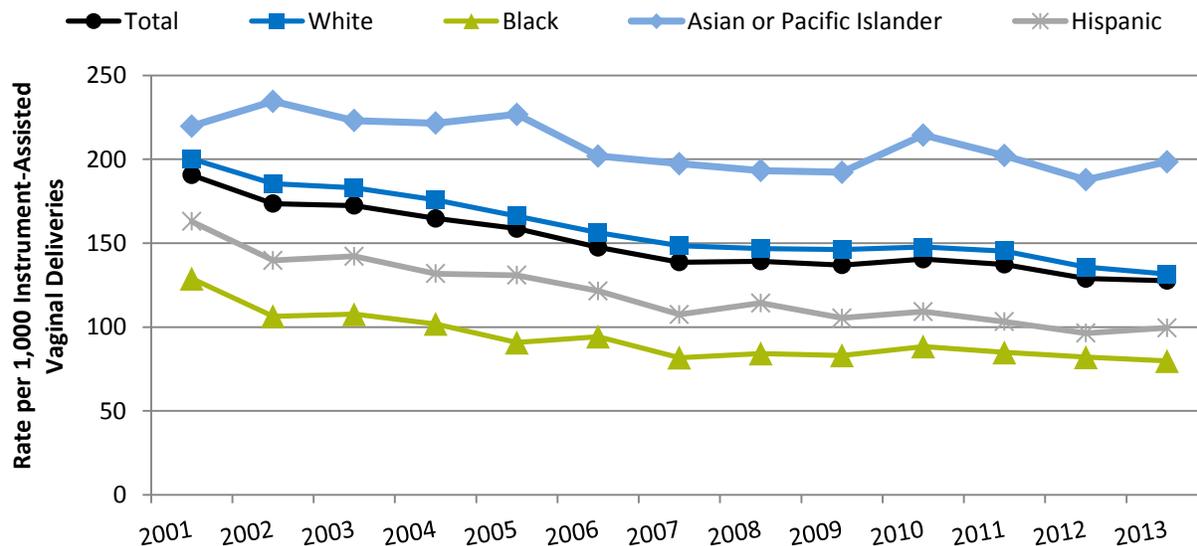
Key: HAC = hospital-acquired condition.

Source: Agency for Healthcare Research and Quality, Medicare Patient Safety Monitoring System, 2010-2014; Centers for Disease Control and Prevention, National Healthcare Safety Network, 2010-2014; and Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010-2011 and State Inpatient Databases 2012-2013 quality analysis files.

- From 2010 to 2014, the overall rate of hospital-acquired conditions declined by 17%, from 145 to 121 per 1,000 hospital discharges.
- Large declines were observed in rates of adverse drug events, catheter-associated urinary tract infections, and pressure ulcers.

Patient Safety Disparities were uncommon; more than 70% of racial, ethnic, and income-related contrasts did not indicate a disparity. However, when present at baseline, only about 30% of disparities grew smaller. Moreover, new disparities appeared in areas that had no disparities before. Disparities in patient safety have not been well studied. However, as improvements in patient safety are made, it is important to ensure that care is made safer for all Americans.

Patient Safety: Obstetric trauma per 1,000 instrument-assisted vaginal deliveries, by race/ethnicity, 2001-2013



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases disparities analysis file, 2001-2013, and AHRQ Quality Indicators, version 4.4.

- From 2001 to 2013, the rate of obstetric trauma associated with instrument-assisted vaginal deliveries fell overall and for all racial/ethnic groups.
- Blacks and Hispanics had lower rates of obstetric trauma associated with instrument-assisted vaginal deliveries than Whites in all years.
- The gap between the Asian or Pacific Islander rate and the White rate was not statistically significant in 2001 but grew larger over time.

The **Michigan Health and Hospital Association Keystone Center Hospital Engagement Network** aims to reduce preventable hospital-acquired conditions. From 2011 through 2014, nearly 100 hospitals participated in the network and saved more than \$40 million in health care costs per year by reducing patient harm.² Michigan hospitals continue to improve central-line-associated bloodstream infection (CLABSI) and ventilator-associated event rates and are implementing prevention, detection, and treatment strategies to reduce sedation and delirium in the intensive care unit. From 2004 through 2014, there was a reduction in CLABSI of 69 percent.³

Priority 2



Person- and Family-Centered Care: Ensuring that each person and family is engaged as partners in their care

The National Quality Strategy calls on all stakeholders to promote person- and family- centered care. Person-centered care ensures that each person and family is engaged as partners in their care. It means defining success not just by the resolution of clinical syndromes but also by whether patients achieve their desired outcomes. Care should adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds.

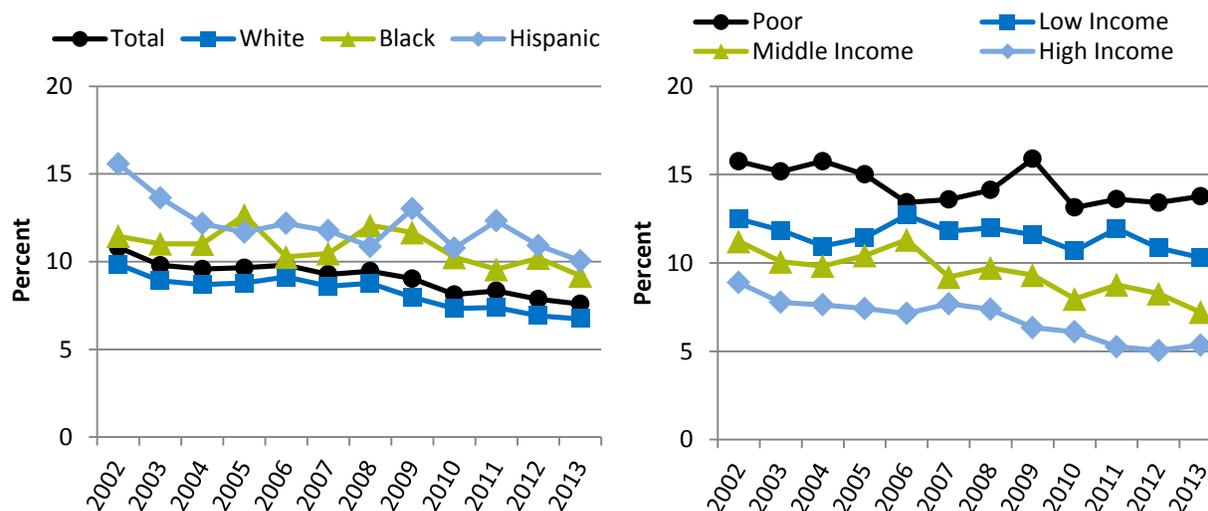
A study published in 2015 in the *Journal of General Internal Medicine* examined the implementation of a patient-centered medical home (PCMH) pilot program in 15 small and medium primary care practices in Colorado. Over a 3-year period, the study found that the patient-centered primary care delivered in the PCMH model led to sustained decreases in the number of annual emergency department visits and primary care visits, as well as increased screening for some types of cancer.⁴

Person-centered care also needs to be integrated outside of medical homes in the fee-for-service settings in which most patients receive care. As outlined in the National Quality Strategy, successful person-centered care entails more than just the successful completion of clinical care; it also means that patients achieve their own desired outcomes.

Person-Centered Care improved quickly, but Person-Centered Care Disparities were common, especially for Hispanics and poor people. As is true for access, disparities by income are larger than disparities by race/ethnicity. 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.

Such efforts have led to widespread improvements in person-centered care; 80% of measures tracked showed improvement. However, many disparities exist and only about 30% of them are getting smaller over time. We expect an additional decrease in disparities, in part, because of enforcement of Section 1557 of the Affordable Care Act, which prohibits organizations from discriminating on the grounds of race, color, national origin, age, disability or sex, under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by HHS, including the Health Insurance Marketplaces.

Person-Centered Care: Adults who had a doctor's office or clinic visit in the last 12 months who reported poor communication with health providers, by race/ethnicity and income, 2002-2013



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2013.
Note: Adults who reported that their 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.

- From 2002 to 2013, the percentage of adults who reported poor communication with their health providers significantly decreased overall and among all racial/ethnic and income groups.
- Hispanics were more likely than Whites to report poor communication in all years; this gap did not change over time.
- Blacks were more likely than Whites to report poor communication in all years except 2006; this gap did not change over time.
- Poor, low-income, and middle-income families were more likely than high-income families to report poor communication in all years. The gap between middle- and high-income families did not change over time while the gaps between poor and high-income families and between low- and high-income families grew larger.

PatientsLikeMe is an online patient community that uses social networking to facilitate communication among people with chronic illnesses. The social network, a leader among similar organizations such as DailyStrength, CareAcross, and CureTogether, has demonstrated that open access to information facilitated by this model has strong potential to nurture patient engagement. A study published in *Neurology* in 2015 found that PatientsLikeMe usage increased epilepsy self-management and self-efficacy.⁵ A separate study published in 2015 in the same journal examined the data of site users diagnosed with amyotrophic lateral sclerosis (ALS) and found that small temporary plateaus and reversals in patient status are more common than previously believed and should not be interpreted as an ALS treatment effect.⁶ By engaging patients with diseases to communicate with others about their symptoms, PatientsLikeMe showed the potential for its patient community to contribute to the conversation around rare diseases and treatments.

Priority 3



Care Coordination: Promoting effective communication and coordination of care

The National Quality Strategy calls on all stakeholders to promote effective communication and coordination of care across the health care system. Navigating today's health care system is complicated. Patients receiving care often interact with many physicians, nurses, medical assistants, or other trained professionals across multiple settings, a situation especially true for the sickest populations. More than two-thirds of Medicare beneficiaries have at least two chronic conditions, and 14% of beneficiaries have more than six chronic conditions. Nearly 50% of beneficiaries with more than six chronic conditions have more than 13 doctor visits per year, and in 2010 accounted for 70% of Medicare hospital readmissions.⁷

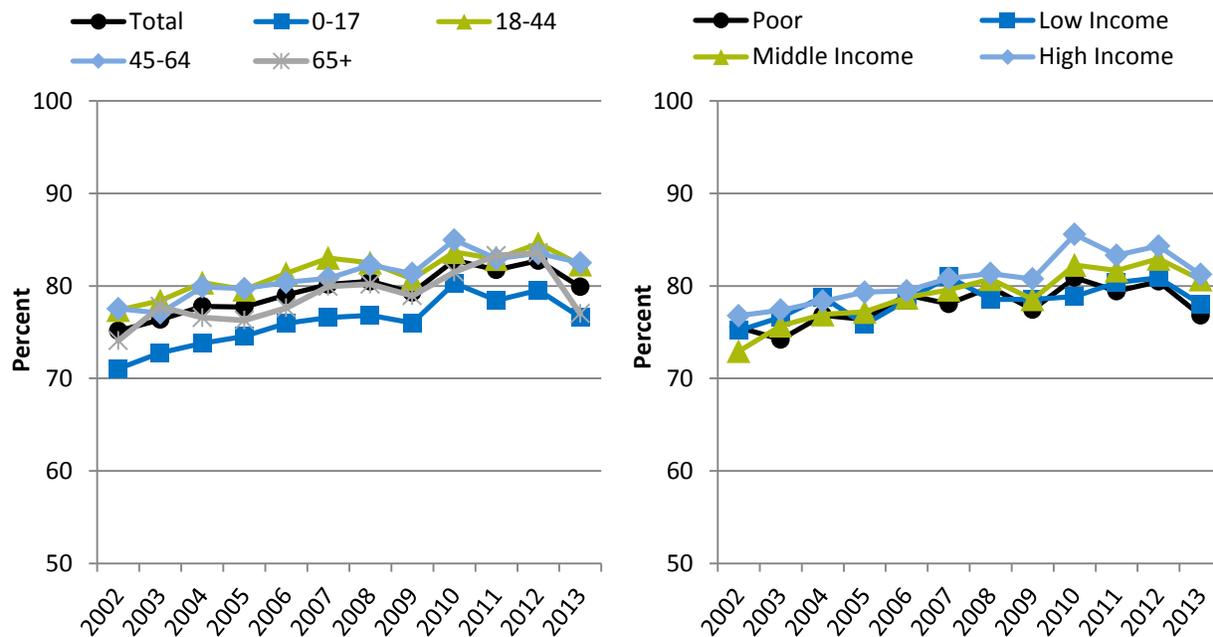
When health care providers coordinate with each other, outcomes improve. Improved coordination decreases medication errors, unnecessary or repetitive diagnostic tests, unnecessary emergency department visits, and preventable hospital admissions and readmissions, all of which together lead to higher quality of care, improved health outcomes, and lower costs. Because delivery of coordinated care necessarily brings together disparate sectors of the health and health care system, improving care coordination offers a potential opportunity for drastically improving care quality that could save \$240 billion a year.⁸

There are few quality measures that assess the process of coordinating care other than at the time of discharge from a hospital. Most care coordination measures in use examine health care utilization that could have been prevented, in part, by more coordinated care, such as readmissions and avoidable hospitalizations and emergency department visits. Among these measures, **improvement in Care Coordination lagged behind** other priorities, and **Care Coordination Disparities were common**.

Effective care coordination requires explicit attention to the many settings in which patients receive care as well as attention to the infrastructure to support information exchange across these sites. The CMS Community-based Transitions Program provides funding to test models for improving care transitions for high-risk Medicare patients by using services to manage patients' transitions effectively.

Care coordination also is facilitated by the meaningful use and interoperability of health information technology. The Health Information Technology for Economic and Clinical Health 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. For example, certification of a patient-centered longitudinal care plan facilitates documentation of a shared care plan for the entire care team, including the patient and his or her family. Ineffective care coordination can lead to preventable emergency department visits, admissions, and readmissions. Perhaps because concerted attention to improving care coordination is relatively recent, fewer than half of measures have documented improvement.

Care Coordination: People who report that their usual source of care usually asks about prescription medications and treatments from other doctors, by age and income, 2002-2013



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2013.

- From 2002 to 2013, the percentage of people who reported that their usual source of care usually asked about prescription medications and treatments from other doctors increased overall and among all age and income groups.
- In all years, children were less likely than adults ages 18-44 to have a provider who asks about care from other doctors.
- Before 2010, there were few income-related disparities. Since 2010, people in poor and low-income families have been less likely than people in high-income families to have a provider who asks about care from other doctors. These represent new disparities in care coordination.

An organization focused on improving care coordination is the **Lourie Center for Children’s Social and Emotional Wellness**, which provides coordinated health services to 4,000 children in the Washington, DC, area. The Center’s Parent-Child Clinical Services Program, a licensed outpatient mental health clinic, uses a family-centered developmental approach to provide assessment, treatment, and consultation services to families and children that promote healthy development, enhance parenting capacity, and foster positive parent-child relationships. A study published in *Attachment & Human Development* in January 2016 examined the efficacy of the attachment-based experiential intervention program used in the Center’s Parent-Child Clinical Services Program. Despite the small sample size, the authors found strong empirical evidence of positive behavioral change in study participants. This finding holds promise that coordination of mental health care enhances the capacity for changes in functioning and behavior between parents and their children.⁹

Priority 4



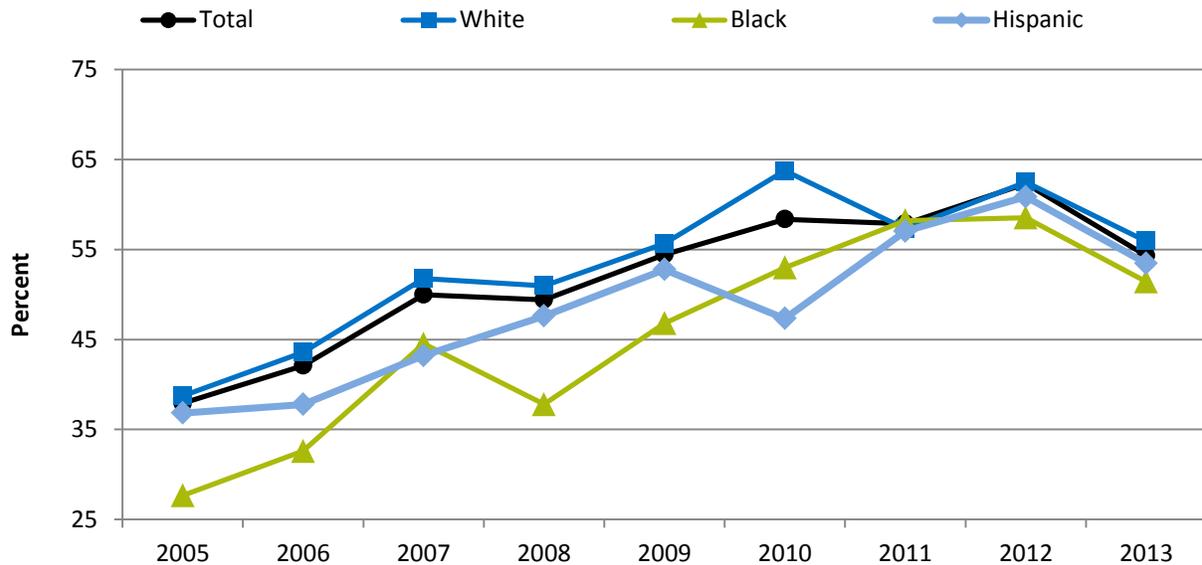
***Effective Prevention and Treatment:** Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease*

The National Quality Strategy calls on all stakeholders to promote effective prevention and treatment of the leading causes of morbidity and mortality. A small number of chronic illnesses affect a large percentage of the population and account for a majority of deaths and health care expenditures in the United States. In particular, heart disease has been the leading cause of death in the United States for decades. It kills nearly one in four Americans and costs \$312 billion per year, more than 10% of annual health expenditures.¹⁰ Improving the quality of American health care thus demands a focus on the prevention and treatment of cardiovascular disease.

The prevalence of cardiovascular disease risk factors and lack of public awareness compound the problem. According to the Centers for Disease Control and Prevention, in 2012, 29% of American adults had hypertension and another third had prehypertension—both early warning signs of cardiovascular disease—but only 52% of those people with hypertension had their condition under control.¹¹ Successful prevention and treatment of cardiovascular disease holds real promise to significantly improve the nation’s clinical and economic health. AHRQ is focusing resources in this important area through EvidenceNOW, a grant initiative dedicated to helping thousands of small and medium primary care practices across the country use the latest evidence to improve the heart health of millions of Americans.

Effective Treatment improved, and Effective Treatment Disparities were uncommon, with several getting smaller over time. Since CMS began publicly reporting measures of hospital quality on the Hospital Compare Web site in 2005, these measures dominated the list of effective treatment measures tracked in this report. In the last several reports, many CMS measures achieved overall performance levels of 95% or better and were dropped from the report. The remaining measures of effective treatment have also done well, with about 60% showing improvement. Moreover, disparities are less common than in many other priorities; of these disparities, about 45% were getting smaller over time.

Effective Prevention and Treatment: Hospital patients with heart attack given fibrinolytic medication within 30 minutes of arrival, by race, 2005-2013



Source: Centers for Medicare & Medicaid Services, Medicare Quality Improvement Organization Program, 2005-2013.

- From 2005 to 2013, the percentage of hospital patients with heart attack who received timely fibrinolytic medication, which may reduce the amount of damage to the heart, improved overall and for all racial/ethnic groups.
- From 2005 to 2010, the percentage of hospital patients with heart attack who received timely fibrinolytic medication was lower for Blacks than for Whites. By 2011, this disparity had been eliminated.

An organization working toward improved primary care for patients with common chronic conditions is the **Better Health Partnership**. The Partnership delivers better and more affordable care in northeast Ohio to address the leading causes of morbidity and mortality. The Partnership currently publishes scores on the quality of care, primarily for diabetes and cardiovascular disease, delivered by more than 700 providers in 68 primary care practices of 9 health systems in Cuyahoga County and other adjacent counties.¹²

Between 2010 and 2013, the Partnership reduced hospitalizations for patients with diabetes, hypertension, angina, or heart failure by 10%, saving \$20 million in health care costs. From 2014 to 2015, the Partnership's practices showed high performance on blood pressure control and cholesterol management measures compared with national averages reported by the National Committee for Quality Assurance.¹³ The national Million Hearts[®] initiative includes measures tracking performance on these two conditions; improved performance on these conditions is a key facet of the initiative's goal of preventing 1 million heart attacks and strokes in 5 years through improved heart health care quality.

Priority 5



Healthy Living: Working with communities to promote wide use of best practices to enable healthy living

The National Quality Strategy calls on all stakeholders to promote the health and well-being of communities across the health care system and beyond. Although the United States spends more per capita on health care than any country in the world, its citizens as a whole are the least healthy in the developed world.¹⁴ Nearly 45% of Americans have at least one chronic condition, and chronic conditions are responsible for 70% of the nation's deaths and 75% of health care spending.¹⁵

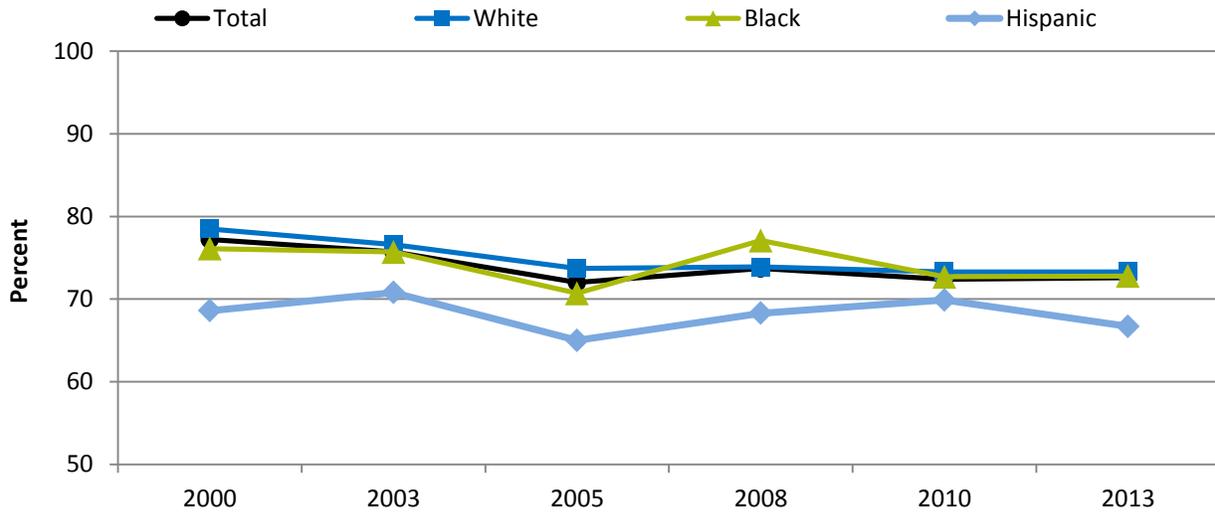
Many illnesses associated with chronic conditions are related to unhealthy lifestyle behaviors, environmental hazards, and poor social supports and can be prevented by increasing access to effective clinical preventive services and promoting community interventions that advance public and population health. Working with communities is critical to ensure that immunizations and early detection and prevention services reach everyone who needs them and to build healthy neighborhoods and support networks.

Public health spending has been shown to be particularly effective for lower income, and often higher need, communities, with 21 to 44% greater health and economic effects in low-income communities compared with the average-income community.¹⁶ Increasing public health spending and improving access to preventive care thus holds promise as a cost-efficient way to create healthier communities, reduce the personal and economic burden of chronic illnesses, and improve quality of life while reducing disparities throughout the United States.

Promoting healthy lifestyles that prevent disease and disability is better for people and more efficient than treating conditions after organ damage has been done. Measures of healthy living are long term and difficult to evaluate. As a result, measures of healthy living used in this report focus on receipt of indicated counseling and preventive services rather than actual achievement of a healthy lifestyle. For example, provider counseling about smoking cessation is tracked but the prevalence of smoking is not since the latter is influenced by many factors other than health care.

Among these measures, **progress in Healthy Living lagged behind** other priorities; with rare exceptions, receipt of recommended clinical preventive services has not increased substantially over the past decade. However, **Healthy Living disparities were uncommon**, with several getting smaller over time. This may reflect the broad availability of clinical preventive services and lifestyle counseling to most Americans even as large differences in the attainment of healthy lifestyles and environments exist across populations.

Healthy Living: Women ages 50-74 who reported they had a mammogram within the past 2 years, by race/ethnicity, 2000-2013



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2013.

Note: Rates are age adjusted to the 2000 U.S. standard population.

- From 2000 to 2013, the percentage of women ages 50-74 who reported they had a mammogram within the past 2 years decreased overall, especially for White women.
- Trends for Black and Hispanic women were not statistically significant.
- In most years, Hispanic women were less likely than White women to have a mammogram. However, this gap has narrowed over time.
- Black and White women had similar rates of mammography in all years.

An organization working to improve healthy living is the **Minnesota State Health Improvement Program (SHIP)**. SHIP addresses the two largest causes of chronic disease and premature death in Minnesota and nationally: obesity caused by poor nutrition and insufficient physical activity, and commercial tobacco use. By August 2015, the program increased access to healthy food options and physical activity opportunities for approximately 339,000 students. Minnesota SHIP collaborated with 540 employers on comprehensive workplace wellness initiatives for 62,000 employees, including promotion of healthy eating, active living, and tobacco-free living, and support for breastfeeding.

Working with community-based organizations, Minnesota SHIP created opportunities to make biking and walking easier at 180 sites and increased access to fresh fruits and vegetables at nearly 375 locations. In addition, Minnesota SHIP encouraged smoke-free housing policies at nearly 365 rental properties, protecting 17,000 residents from secondhand smoke. Among public housing properties that implemented smoke-free policies, indoor secondhand smoke exposure was reduced by over 46%.¹⁷

Priority 6



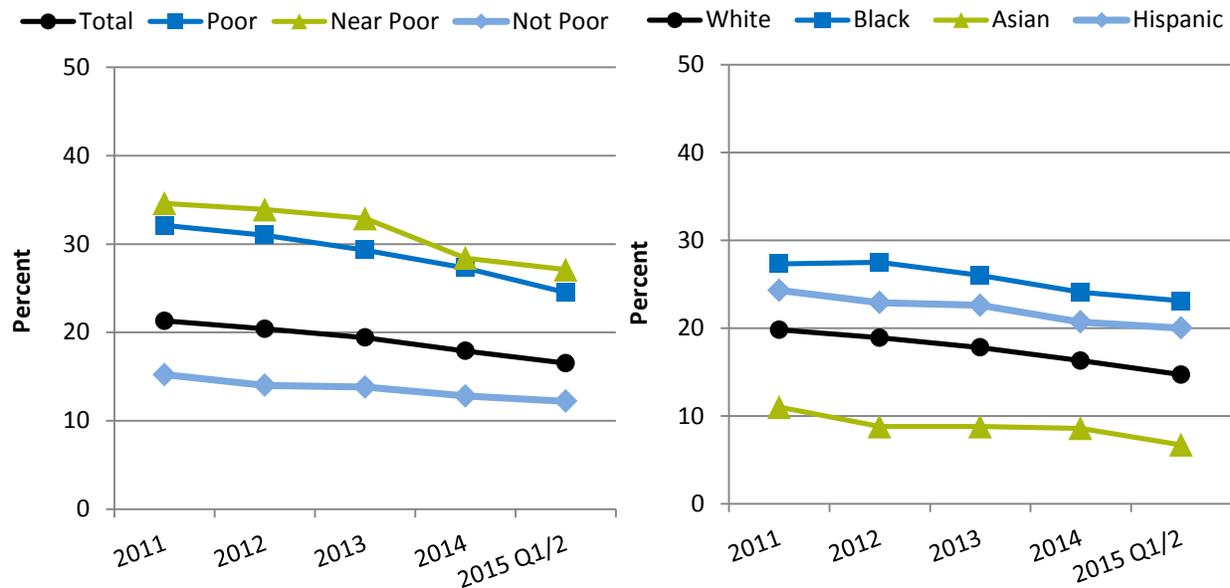
***Care Affordability:** Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models*

The National Quality Strategy calls on all stakeholders to make quality care more affordable across the health care system. In 2014, annual health and health care expenditures in the United States reached \$3 trillion and accounted for 17.5% of the nation's gross domestic product.¹⁸ Health expenditures have historically grown faster than the rest of the economy, leading to an increase in the national debt, a decrease in the funds available for other public investments, and an increase in business and household budgets.

Numerous studies estimate that roughly 30% of health care spending produces little net value to the system in the form of improved health outcomes. Such spending includes unnecessary services, excess administrative costs, and inefficient delivery.^{19,20} Fee-for-service payment models, which reward providers based on the quantity of services provided rather than the quality of care and patient outcomes, can, in many cases, result in higher costs and poorer outcomes. Reforming the country's current payment and care delivery systems to address these problems presents enormous opportunities to reduce the cost of care and increase both quality of care and population health.

While data are limited for measures related to affordable care, available data show that **Care Affordability improved since 2010 when the Affordable Care Act was passed**, after worsening from 2002 to 2010. In addition, some **Care Affordability Disparities have been getting smaller**, including income-related disparities in problems paying medical bills. Since 2010, the Affordable Care Act has made health insurance accessible to millions of Americans with limited financial resources.

Care Affordability: People under age 65 who were in families having problems paying medical bills in the past year, by poverty status and race/ethnicity, 2011-2015 Q2



Key: Q = quarter.

Source: Cohen RA, Schiller JS. Problems paying medical bills among persons under age 65: early release of estimates from the National Health Interview Survey, 2011-June 2015. Hyattsville, MD: National Center for Health Statistics; 2015. <http://www.cdc.gov/nchs/nhis/releases.htm>.

- From 2011 to the first half of 2015, the percentage of people under age 65 in families having problems paying medical bills decreased overall and for all poverty status and racial/ethnic groups.
- In all years, people in poor and near-poor families were more likely to have problems paying medical bills than people in families that were not poor. The gaps between people in poor and not poor families and between near-poor and not poor families have narrowed over time.
- In all years, compared with Whites, Blacks and Hispanics were more likely to have problems paying medical bills while Asians were less likely to have problems. None of these gaps were changing over time.

An organization working to reduce the cost of care is the **Camden Coalition of Healthcare Providers**. The Coalition analyzes health information exchange data to assign high-utilizing patients to a care management team that coordinates visits, reviews medications, and arranges postdischarge primary care and home visits. The first cohort of 36 patients enrolled in the program saw significant decreases in hospital utilization and total cost of care. These patients averaged 62 hospital and emergency department visits per month at an average total cost of \$1.2 million before the intervention and averaged 37 hospital and emergency department visits per month at an average total cost of \$500,000 afterward.²¹ Monthly medical costs per “superutilizer” dropped 56%, from \$33,333 to \$14,597.²²

LOOKING FORWARD

The National Quality Strategy continues to serve as a catalyst and a compass for stakeholders to provide better, more affordable care for the individual and the community. The *National Healthcare Quality and Disparities Report* continues to track the performance of the nation on health care access, quality, and disparities. The *National Healthcare Quality and Disparities Report* data demonstrate significant progress in some areas and identify other areas that merit more attention based on the priorities of the National Quality Strategy.

Improving the health of the population can only occur if Americans can access health care services, and the 2015 Quality and Disparities Report demonstrates that access to care continues to improve as a result of the Affordable Care Act. As of March 2016, more than 12.7 million people selected or were automatically re-enrolled for health care coverage through the Health Insurance Marketplaces in all 50 states and the District of Columbia.²³ Moreover, while racial, ethnic, and income-related disparities in access persist, many are getting smaller.

Five years after the National Quality Strategy identified six priorities to focus efforts on quality improvement, progress has been made in many priority areas, but wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The numbers below are just one way of illustrating progress against the National Quality Strategy priorities.

- **Effective Treatment** has a high percentage (58%) of measures that are improving and fewer disparities than other priorities have. When disparities are present, a higher percentage of disparities are getting smaller.
- **Care Coordination** has a lower percentage of measures that are improving. Data that track Care Coordination are limited, due to challenges in measuring this priority area. Stakeholders might seek to improve care coordination for all patients and develop tools that measure care coordination.
- **Patient Safety, Person-Centered Care, and Healthy Living** have a high percentage of measures that are improving but few disparities that are getting smaller. Stakeholders might seek to improve these priorities by focusing on specific populations whose care is worse than care received by others.
 - **Patient Safety** had gains, with 60% of safety measures improving, led by a 17% reduction in hospital-acquired conditions;
 - **Person-and Family-Centered Care** had 80% of measures improve; and
 - **Healthy Living** had 60% of measures improve.
- Data regarding **Care Affordability** are limited, but several measures have improved since the Affordable Care Act made health insurance accessible to many Americans with limited financial resources. Improvement should begin with the development of reliable metrics.

Federal and state quality initiatives have used the National Quality Strategy to establish frameworks centered on the aims and priorities for improving health and health care quality and achieving cost savings. Together, these initiatives touch the lives of millions of Americans. CMS used the National Quality Strategy aims and priorities as a foundation to develop the CMS Quality Strategy, which guides the activities of all agency components. At the state level, the California Department of Health Care Services adopted the National Quality Strategy's framework to develop its Strategy for Quality Improvement in Health Care.

Other promising programs hold hope for future improvement in the priority areas:

- For patient safety, national efforts saved 87,000 lives and nearly \$20 billion in health care costs between 2010 and 2014.²⁴
- For care coordination and person- and family-centered care, the recently announced Accountable Health Communities Model is the CMS Innovation Center model to focus on the health-related social needs of Medicare and Medicaid beneficiaries, by coordinating services between clinical and community-based services at the local level.
- For effective treatment, the Centers for Disease Control and Prevention continues to work toward the goal of preventing 1 million heart attacks and strokes by 2017.
- For healthy living, the Centers for Disease Control and Prevention Community Health Improvement Navigator program provides tools and resources for collaborative approaches to community health improvement, establishes and maintains effective collaborations, and finds interventions that work for the greatest impact on health and well-being.²⁵
- For affordability, the Affordable Care Act provides tools, such as Accountable Care Organizations, to move our health care system toward one that rewards doctors based on the quality, not just the quantity, of care they give patients. As of January 2016, there are 121 new participants in Medicare Accountable Care Organization initiatives designed to improve the care patients receive in the health care system while lowering costs.²⁶

As health care delivery continues to evolve, the framework of the National Quality Strategy and the tracking of the *National Healthcare Quality and Disparities Report* can help identify system successes that should be celebrated as well as opportunities for improvement.

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