The Health Care Scene as 2005 Opens: How Are We Doing?

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As 2005 opens, it seems like a good time to take stock. Where are we in health care? From the financing perspective, capitation is out and pay-for-performance is in. This change implies being able to measure quality routinely, a capability still out of reach for many organizations.

The use of health care information technology (HIT) seems like it might finally be about to take off. The naming of David Brailer as the national coordinator for HIT in the Department of Health and Human Services represents a vitally important step, but enthusiasm around this has been tempered because his very modest budget was not approved [1]. Still, many initiatives around the country are moving ahead. For example, a group in Massachusetts is focusing on electronic health record adoption, clinical data exchange, and implementation of computerized physician order entry across the state [2]. Called the Massachusetts eHealth Collaborative, the group has received $50 million from Blue Cross of Massachusetts to begin its efforts. If such efforts are successful, it should be possible to substantially improve the quality and safety of care, in large part by delivering decision support but also by using the information as a tool for measuring and improving quality.

In many markets, pay-for-performance contracting will make it attractive to organizations to begin investing in HIT and to work more actively on improving the quality of care they deliver, a change that will be of great interest to JCOM readers. Additional quality measurement also poses challenges: many organizations face a bewildering array of quality measurement requests coming from the Joint Commission, the states, national organizations such as the National Committee for Quality Assurance and National Quality Forum, and groups such as Leapfrog, among others. Increasingly, these groups are trying to coordinate their requests; as an example, the most recent Leapfrog standard is based on the National Quality Forum list of safe practices. This is welcome, but more coordination is needed.

But at ground level, how are we doing with safety and quality? Although it has been over 5 years since the landmark *To Err Is Human* report was released by the Institute of Medicine [3], a recent evaluation convened by the Commonwealth Fund concluded that while some progress has been made with respect to the safety of U.S. health care, there is still a long way to go [4]. For example, for the first 3 Leapfrog leaps, only 2% of reporting hospitals have implemented computerized physician order entry [5], 10% of hospitals have an intensive care–trained physician present in the intensive care unit full-time [6], and a range of 3% to 32% of hospitals have implemented evidence-based referrals for 6 designated conditions [7]. Furthermore, we don't have a sound, evidence-based approach for measuring safety on an ongoing basis. On the plus side, from the anecdotal perspective, it appears that the safety climate has improved substantially around the country, and many organizations now have patient safety officers. Finally, we have a set of evidence-based practices that hospitals can use to improve safety developed by the National Quality Forum. We also have an emerging evidence base around the magnitude of the safety problem, including ambulatory safety—research largely sponsored by the Agency for Healthcare Research and Quality.

On the quality front, the Institute of Medicine's *Crossing the Quality Chasm* report provided a vision of the future of quality [8], although it didn't provide a detailed map of how to achieve this. The recent report from Rand that assessed the nation's quality of health care suggested that the chance of getting high quality care across a large array of measures was little better than a coin flip [9]. Although safety has been the subject of many of the recent headlines and is very important, it seems likely that the societal benefit we could realize from improving quality would be much greater than for safety, so we need to do both.

Furthermore, efficiency may be the most pressing issue of all. We already spend more of our gross national product on health care than any industrialized nation, yet we score poorly on a wide array of population health measures. It is not clear how long American industry can stand for this type of performance.

All of this makes the kind of work that we publish in JCOM more important than ever. We seek practical examples of how to improve the safety, quality, and efficiency of health care. While information technology will represent an essential tool for making these changes and assessing their impact, it is only a tool. We do expect to publish more reports that leverage HIT in one way or another. But successful interventions will likely involve multiple strategies. We are interested in the full spectrum of ways for closing quality gaps.

Changing the way that health care is delivered—as the

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readers of JCOM know—is painstaking work. Often, small details or nuances in the approaches taken make a difference. Descriptions of successes (or failures) that address these issues will be of help to our readership as they conduct their own efforts. We'd like to receive more original reports than in previous years. Our goal is to see the care delivered in this country improve, and we aim to publish papers that will advance the ball in this vitally important area.

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