Editorial

Building the Path to High-Quality Care

At this writing, the future shape of U.S. health care is the focus of intense debate. Notwithstanding sharp differences in proposed approaches to guarantee access to high-quality care at an affordable price, an emerging consensus among researchers, policy makers, and the public reflects the urgency of improving health care quality and value. Last year AHRQ's annual report to the Congress on quality, the *National Healthcare Quality Report*, found that while quality had improved overall in all settings and population groups, the rate of that improvement has diminished. Moreover, the overall rate of improvement stands in sharp contrast to the annual increase in health spending for the same year. For example, in 2006 the increase in improvement was 2.3 percent in contrast to a 6.7 percent increase in annual spending (Brady, Ho, and Clancy 2008). While the overall costs of health care have received continued scrutiny, the question of what are we getting for our substantial investment has only recently emerged as a primary focus for reform efforts.

The larger context for these discussions is shaped by a global economic decline, which magnifies the burden on U.S. employers who provide insurance to their workers. While domestic spending freezes may be on the near horizon, celebration of and continued support for the leadership role of the United States in basic science and clinical discovery represents an area of bipartisan consensus. Far less attention has been focused on the delay in applying the products of biomedical science to the benefit of patient care.

An example of success in 2007 was removal of the quality measure that assesses the delivery of beta blockers to individuals who have had a heart attack to reduce subsequent mortality from the list of measures used to score health plan performance, because performance has become routinely excellent. Any sense of elation, however, is tempered by the slow speed of improvement, that is, the landmark clinical trial results from which this measure derives were published 25 years ago (Brady, Ho, and Clancy 2008). This is but one example of many illustrating that we face a longstanding challenge assuring rapid uptake of scientific advances.

Health services researchers have made enduring contributions to the development and use of measures to assess health care quality. From McGlynn's seminal study in 2003 (McGlynn et al. 2003) to increasingly sophisticated cross-national comparisons (Schoen et al. 2007), the products of research are now familiar to millions of Americans. Whether examining peer-reviewed publications or quality report cards, these assessments consistently reflect a substantial and persistent gap between high-quality, evidence-based care and that which is routinely delivered. Public reporting has been associated with improvements in performance, but the effect has been less than dramatic (Hibbard, Stockard, and Tusler 2003, 2005a, b).

Recent endeavors of the research community have begun to focus on the following important questions for policy and for our populations' health: why has this gap remained resistant to growing interest in improving quality; how can we achieve reliability in health care; which policy levers have the greatest impact; and what resources are required to do so?

Two articles published in this issue of the journal focus on important aspects of what has been referred to as the science of improvement. Titler et al. (2009) report on the outcome of a multifaceted intervention to improve pain management for elderly patients with hip fractures. In this instance, what to do—the evidence base—is clear, and the number of patients and impact on early ambulation and fewer adverse outcomes is significant, yet the opportunity gap remains. Using Rogers' diffusion of innovation model, the researchers designed a randomized experiment in 12 hospitals.

In addition to an evidence-based guideline on pain management received by all participants, experimental hospitals received an intervention that addressed characteristics of the innovation (evidence-based acute pain management for adults), the users (physicians, nurses, and others), the social system or context, and the communication strategies. The results demonstrated a statistically significant effect on decreased pain intensity and a positive effect on clinicians' practice behaviors and barriers to use of evidence-based acute pain management practices. While the design, randomization at the hospital level, was strong, it did not permit assessment of which components of the intervention were most effective.

Liu et al. (2009) focused on the organizational costs of a depression care quality improvement program, based on the best possible evidence, within the Veterans Health Administration system (VA). In this study, the research team focused not on the patient care costs, but on the organizational resources required for the initial phases of an evidence-based program implementation. All activities, from time spent reading e-mail and holding conference calls

to honoraria for participants to time required by members of the technical support team, were carefully accounted for with intriguing results. Estimated total costs for program implementation were \$100,000 per region for each of three regions. Integration of the program into the VA's electronic health record system accounted for one-third of requisite resources, and incorporation of the new model into standard policies and culture was also costly. Importantly, the authors raise the question of whether the costs of sequential spread will decrease over time.

These studies stand in sharp contrast to policy and market expectations of efforts to improve quality and value. Today there are numerous websites and other sources for publicly reported information on quality of hospitals—including patient experience, nursing homes, home health agencies and health plans, and the demands for this information are strong and growing. How transparent information filters to those at the front lines of care has received far less attention (Ginsburg 2003). Instead, belief in the existence of “transformative” interventions—from health information technology (IT) to disease management to many others—which will effect dramatic improvements, feeds the illusion that clarifying the targets of opportunity is equivalent to addressing them. Moreover, the urgent need to build the science has not yet been clearly articulated in a persuasive way to encourage much-needed investments in improvement methods, training, and demonstrations.

The implications of this challenge for the research community are substantial. As described in both studies by Titler, Liu and colleagues in this issue, this work is far more challenging than some traditional research areas, such as descriptive analyses of large databases, because it requires effective engagement with policy makers, clinicians, health care leaders and patients. Institutional Review Board approval, methods development, and new models for training future researchers are just a few of the areas that require thoughtful examination and change.

In addition, effective transition from a health care environment that is now highly fragmented and too often chaotic to one that is information-rich and patient-focused will require new approaches to training clinicians and health care leaders to become informed consumers of the products of improvement science. Promotion and tenure requirements that implicitly or explicitly celebrate discoveries and presume that their application is a lesser contribution also create a barrier to aligning inquiry and evaluation with improved health and health care.

Despite these challenges, the potential return on investing in improvement science is too important to ignore. Health care organizations, clinicians

and patients desperately need to know when their well-intended efforts are likely to fail and how to spread isolated successes broadly. Researchers attempting to address the question “Why aren’t we doing better?” will discover that classic hypothesis testing may not be a good fit, and they will also need to develop skills in collaboration with those delivering care, new methods, and a clear sense of a viable career path. Indeed, current and future researchers may find a more logical focus for their work in research entities tightly linked with health care organizations. Addressing these issues as a research community will not be straightforward, but failure to respond would represent the ultimate missed opportunity.

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