CyberSpace

So many reports, so little time

Compiled by A L Scheffler

IOM rolls on

The Institute of Medicine (IOM) in late 2002 issued a series of reports on critical changes needed to improve medical care, public health, and clinical research in the US. Following our brief summaries:

- 19 November 2002: IOM released *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (**http://www.nap.edu/books/0309087074/html/**). Responding to a request from Tommy Thompson, the US Health Secretary (and former Governor of the State of Wisconsin), the report "sets forth a strategy for health system reform in which states are used as laboratories for the design, implementation, and testing of alternative redesign strategies". Demonstration projects in five areas—chronic care, primary care, information and communications technology infrastructure, state health insurance, and liability—could begin in 2003 and last up to 5 years. The report cautions that for these "seeds of innovation" to flower, steps must be taken "to remove barriers to innovation and to put in place incentives that will encourage redesign and . . . reward high-quality care".
- 11 November 2002: IOM released *The Future of the Public's Health in the 21st Century* (**http://www.nap.edu/books/0309086221/html/**). Given recent missteps in informing the public about various kinds of terrorism, the report rightly emphasizes "communication as a critical core competency of public health practice". It also recommends an "ongoing dialogue should be maintained between medical and public health officials and editors and journalists" at local and national levels "to improve their ability to accurately inform and communicate with the public, communities and other actors in the public health system".
- 4 November 2002: IOM released *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century* (**http://www.nap.edu/books/030908542X/html/**). This report recommends expansion of professional education for public health beyond traditional areas of epidemiology, biostatistics, environmental health, health services administration, and social and behavioral science to incorporate "eight critical new areas: informatics, genomics, communication, cultural competence, community-based participatory research, policy and law, global health, and ethics".
- 30 October 2002: IOM released *Leadership by Example – Coordinating Government Roles in Improving Health Care Quality* (**http://search.nap.edu/books/0309086163/html/**). The report "encourages the federal government to take full advantage of its influential position to set the quality standard for the health sector" as a whole. "Specifically, regulatory processes should be used to establish clinical data reporting requirements; purchasing strategies should provide rewards to providers who achieve higher levels of quality; [and] health care delivery systems operated by public programs should serve as laboratories for the development of 21st century care models . . .. Key components of the necessary quality infrastructure would include development of standardized performance measures across the six federal health programs (Medicare, Medicaid, the State Children's Health Insurance Program, Department of Defense and Veterans Health Administration programs, and the Indian Health Service); "financial support and incentives to providers to facilitate the development of health information technology infrastructures"; and public release of quality reports (1).
- 3 October 2002: IOM issued *Responsible Research: A Systems Approach to Protecting Research Participants* (**http://www.nap.edu/books/0309084881/html/**). The study authors recommend "extending federal requirements for protection to include every research project involving human participants, regardless of funding source or research setting . . ."(2). They also state the informed consent process in clinical research "should be an ongoing, interactive dialogue between research staff and research participant involving the disclosure and exchange of relevant information, discussion of that information, and assessment of the individual's understanding of the discussion"(3). Effecting these and other reforms would probably require enhanced resources and training, although actual levels are hard to predict because of a paucity of data on how the current system actually operates.

Canada stands up

The National Steering Committee on Patient Safety in Ottawa have recently declared patient safety a top priority for health system reform. Formed in September 2001 under the auspices of the Royal College of Physicians and Surgeons of Canada, the committee released an ambitious report (*Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*) in September 2002. The report posits several key assumptions—for example, "The Canadian health-care system . . . is complex, dynamic and characterized by many competing pressures, particularly the relationship between funding and quality of care"; and "personnel, patients, and all others within the system must be informed participants in understanding that human error is inevitable and that underlying systems factors, including ongoing system change, contribute to most near misses, adverse events and critical incidents"(vi–vii). It then makes recommendations in five areas: systems changes, legal and regulatory processes, measurement and evaluation, education and professional development, and information and communication. To coordinate work on these matters—eventually to be funded at around $50 million over at least 5 years—the report recommends establishment of a non-profit "Canadian Patient Safety Institute" (suggested title). The full report is available for download at **http://rcpsc.medical.org/english/publications/building_a_safer_system_e.pdf**.

MedPAC surprises

Public meetings of MedPAC (Medicare Payment Advisory Commission) normally interest only health economists and industry lobbyists. But last October MedPAC (which makes recommendations to the US government on Medicare coverage criteria and payments to practitioners) hosted an informative discussion on the actual and potential use of financial and non-financial incentives to reward quality improvement activities and outcomes. Featured were Donald Berwick (Institute for Healthcare Improvement), Susanne Delbanco (Leapfrog Group), and Brent James (Intermountain Health Care). Read the complete transcript at **http://www.medpac.gov/public_meetings/transcripts/101102_qualityofcare_KM_transc. pdf**.

On the case

This month the US Agency for Healthcare Research and Quality (AHRQ) officially launches "*Web M&M: Morbidity and Mortality Grand Rounds on the Web*" at **http://webmm.ahrq.gov/**. Each

month the site plans to feature five "current cases and commentaries", along with one "spotlight" case treated in greater depth. (One February commentary—on a case of unexplained apnea under anesthesia—is by *QSHC* Editor Paul Barach.) Editors review cases submitted anonymously, which may later be featured.

So many meetings

- The National Patient Safety Foundation (NPSF) presents "Let's Get Results: Improving the Safety of Patients" on 12–15 March 2003 in Washington, DC (**http://www.mederrors.org/**).
- The NPSF also presents "Integrity and Accountability in Clinical Research" on 6–8 May 2003 in Washington, DC (**http://www.researchsafety.org/**). For a summary report from the 2002 meeting see **http://www.researchsafety.org/download/2002ForumReport.pdf**.
- "Global Evidence for Local Decisions"—the 5th International Conference on the Scientific Basis of Health Services (**http://www.icsbhs.org/index.htm**)—is set for 20–23 September 2003 in Washington, DC. Deadline for submission of abstracts is 14 March 2003.

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