

# Technology and quality and cost of care

As I write this editorial, we who practice medicine face many challenges. Our internal and external environments are changing, and we are asked to do more with less, but we have better tools to perform that work.

We have health care reform, which has been met with such opposition that our government temporarily shutdown in October and faced potential default on the national debt. Although it is uncertain to what degree health care reform will succeed at its primary objectives – the provision of services to the underserved and cost control – it is clear that there are changes ahead that will have an impact on our care delivery. Because many states did not embrace Medicaid, it remains unclear how meaningful care will be provided. The technical challenges in registering for the health care exchanges partnered with the very small penalty for not enrolling are likely to precipitate lower-than-anticipated use of the exchanges, which could result in adverse selection of a sicker patient population, and increase proportional costs for patients enrolled in the health care exchanges. How will we manage this change better?

As a country, we spend 18% of our gross domestic product on health care, which is far more than any other country. Although we strive to improve patient access to care and cost containment, we aspire to these outcomes being born out of value-based care delivery, but lack meaningful supply-side controls that could foster value-based decisions. The boundary aversion in cost containment is pervasive from the way in which the Food and Drug Administration considers drug approvals – focusing on the drug's efficacy and toxicity, but not its cost – to the way in which we approach patient-centered outcomes research with specific

prohibitions from the Patient Centered Outcomes Research Institute to evaluate costs of care.

Despite being in a time of change, challenges, and a great deal of disagreement, we have our sights focused on a better future. We talk about our goals of care delivery – high-quality, patient-centered, collaborative, cost-effective, value-based, efficient – and we are optimistic. Given our tremendous technology advances, it is easy to see how we can use health technology to meet these goals more efficiently and effectively. We see that in this month's issue of COMMUNITY ONCOLOGY, and it can offer us hope.



There are many examples of ways in which we can leverage technology to foster collaboration, improve communication, and efficiently improve patient care in a cost-effective manner. On page 316, Schenken et al evaluate inexpensive solutions to enhance remote care in hospitals that deal with the critical issue of using technology to improve care in areas that do not have easy access to care. Ricci et al discuss planning

evaluation programs for assessing telecommunications applications in community radiation oncology programs (p. 325), and Bold et al demonstrate an effective model for collaborative virtual tumor boards incorporating community-university collaboration (p. 310). These articles offer optimism that we can do more with less and use our health IT tools to enhance quality, value-based, patient-centered, and collaborative care.

A handwritten signature in black ink that reads "Debra A. Patt". The signature is fluid and cursive.

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