




Crossing the Quality Chasm



Janet M. Corrigan
Institute of Medicine
Committee on the
Quality of Health Care
in America

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Background

- IOM Quality Initiative began in 1996
- Issued Reports documenting Quality Gap
 - National Roundtable on Quality, *The Urgent Need to Improve Health Care Quality* (JAMA, Sept. 1998)
 - National Cancer Policy Board, *Ensuring Quality Cancer Care*, 1999

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IOM Roundtable

The burden of harm conveyed by the collective impact of all of our health care quality problems is staggering.

(Chassin et al, 1998)

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Quality of Care in America Committee

- Established in September 1998
- Charge: Establish a plan to achieve a *threshold* improvement in the quality of health care over the next ten years
- Chair: William C. Richardson, Ph.D.,
W. K. Kellogg Foundation

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Quality of Care in America Committee

WILLIAM C. RICHARDSON (*Chair*), W.K. Kellogg Foundation

DONALD M. BERWICK, Institute for Healthcare Improvement

J. CRIS BISGARD, Delta Air Lines, Inc.

LONNIE R. BRISTOW, American Medical Association (Former President)

CHARLES R. BUCK, General Electric Company

CHRISTINE K. CASSEL, The Mount Sinai School of Medicine

MARK R. CHASSIN, The Mount Sinai School of Medicine

MOLLY JOEL COYE, Institute for the Future and Health Technology Center

DON E. DETMER, University of Cambridge, UK

JEROME H. GROSSMAN, John F. Kennedy School of Government, Harvard University

BRENT JAMES, Intermountain Health Care Institute for Health Care Delivery Research

DAVID McK. LAWRENCE, Kaiser Foundation Health Plan, Inc

LUCIAN L. LEAPE, Harvard School of Public Health

ARTHUR LEVIN, Center for Medical Consumers

RHONDA ROBINSON-BEALE, Blue Cross Blue Shield of Michigan

JOSEPH E. SCHERGER, University of California, Irvine College of Medicine

ARTHUR SOUTHAM, Health Systems Design

MARY WAKEFIELD, George Mason University

GAIL L. WARDEN, Henry Ford Health System



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To Err Is Human: Building A Safer Health System



First Report

Committee on
Quality of Health Care
in America

To order: www.nap.edu

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Errors Are A Serious Problem

- Account for as many as 44,000 to 98,000 deaths per year in the U.S.

IOM,1999; Brennan et al, 1991; Thomas et al, 1999)

- More people die from medical errors than from breast cancer or AIDS or motor vehicle accidents.

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Key Findings

- Errors occur because of system failures
- Preventing errors means designing safer systems of care

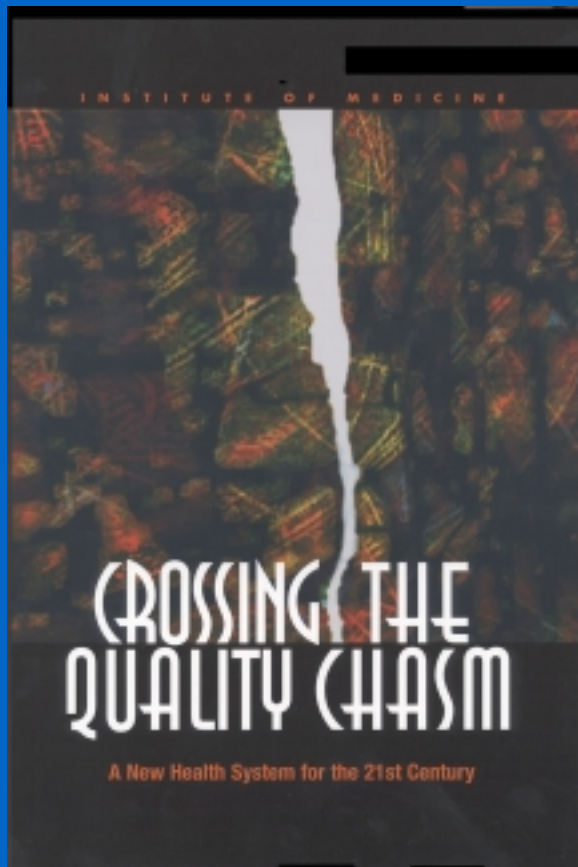
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Response To IOM Report

- 51% of the American public closely followed the media coverage
(Kaiser Family Foundation, 2000)
- Congress appropriated \$50 million for AHRQ patient safety center
- DHHS Quality Interagency Coordinating Committee
- Leapfrog Group
- Many national associations taking action

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Crossing the Quality Chasm



Second Report

Committee on
Quality of Health Care
in America

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Studies Documenting the “Quality Gap”

- Literature review conducted by RAND
 - Over 70 studies documenting quality shortcomings
- Large gaps between the care people should receive and the care they do receive
 - true for preventive, acute and chronic
 - across all health care settings
 - all age groups and geographic areas

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Major Forces Influencing Health Care

- Expanding Knowledge Base
- Chronic Care Needs

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Expanding Knowledge Base

- In 1966, about 100 articles were published each year from RCTs; in 1995, over 10,000 were published annually (Chassin, 1998)

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Many New Drugs and Devices

- In 1998, the FDA:
 - Approved
 - 90 new drugs
 - 30 new molecular entities
 - 124 new uses for already approved drugs
 - 344 generic equivalents
 - 7 over-the-counter drugs
 - Received
 - Over 5000 original applications and notifications for new medical devices

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Significant Investments in R&D

- From 1993-1999:
 - NIH Budget grew from \$11 billion to \$16 billion
 - R&D by pharmaceutical companies doubled to \$24 billion
- \$1 billion invested in the human genome project since 1996

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Increased Chronic Care Needs

- About 100 million people (40% of population) have one or more chronic conditions
- Chronic conditions account for more than two-thirds of health care expenditures (Robert Wood Johnson Foundation, 1996)
- 80/20 Rule: Limited number of conditions account for most of these health care expenditures (Ray et al., 2000)

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Chronic Care Delivery Models

- Planned, systematic approach
- Attention to information and self-management needs of patients
- Multi-disciplinary teams
- Extensive coordination required across settings and clinicians, and over time
- Unfettered and timely access to clinical information is critical

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Delivery System Inadequate

- Dearth of clinical programs with infrastructure to provide full complement of services to chronically ill (Wagner, 1996)
- Physician groups and hospitals operate as silos without benefit of complete information

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Committee's Conclusion

The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

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Five Part Agenda for Change

- Commit to a shared agenda of six aims for improvement
- Adopt “10 rules” to guide the redesign of care processes
- Implement more effective organizational supports
- Focus initial efforts on a set of priority conditions
- Create an environment that fosters improvement

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Aims For Improvement

- Safe
- Timely
- Effective
- Efficient
- Patient-centered
- Equitable

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Ten Simple Rules

Current Approach

Care based on visits
Professional autonomy
Professionals control care
Information is a record
Decision making based on training
& experience
Safety is individual responsibility
Secrecy is necessary
The system reacts to needs
Cost reduction is sought
Professional roles trump the system

New Rule

Continuous Healing Relationships
Customized Care for Patients
Patient is source of control
Information flows freely
Decision making is evidence-based
Safety is a system property
Transparency is necessary
Needs are anticipated
Waste is continuously decreased
Cooperation is a priority

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Building Organizational Supports

Significant efforts must be made to implement state-of-the-art approaches to:

- redesign of care processes
- use of information technology
- knowledge and skills management
- development of effective teams
- coordination of care
- performance and outcome measurement

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Getting Started With Priority Conditions

- AHRQ should identify 15 priority conditions, most of which will be chronic conditions
- Congress should establish a \$1 billion Innovation Fund to seed improvement projects
- Purchasers, health care organizations, and professional groups should develop strategies and implement action plans to substantially improve quality for priority conditions over the next 5 years

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Aligning Environmental Forces

Four Critical Forces:

1. Information Technology
2. Payment
3. Clinical Knowledge
4. Professional Workforce

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Information Technology

- Internet has enormous potential to transform health care
- Applications in many areas
 - evidence-based practice
 - care delivery
 - consumer information and education
 - professional education
 - research
 - population and public health

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IT Can Improve Quality

Safety--computerized physician order-entry reduced adverse drug events by 55% (Bates, 1998)

Effectiveness--reminder systems and computer assisted diagnosis and management improves compliance with practice guidelines (Durieux, 2000; Evans, 1998)

Patient-Centered--Internet can provide access to clinical knowledge, online support groups, customized health education and disease management messages

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IT Can Improve Quality

Timeliness--mothers receiving computer-generated reminders had 25% higher on-time immunization rate for their infants (Alemi, 1996)

Efficiency--9% of redundant lab tests at a hospital could be eliminated using a computerized system (Bates, 1998)

Equity--Internet-based health communication can improve access and provide a broader array of options for interacting with clinicians

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The Internet Helps Activate Consumers

- In 1998, about 1/3 of households had access to the internet; expected to reach 90% by 2010.
- Lots of information, but less quality control
 - 61,000 sites on breast cancer
 - over 40,000 sites on diabetes

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Information Technology

- There must be a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.
- This commitment should lead to the elimination of most handwritten clinical data by 2010

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Barriers to Quality Inherent in Payment Policies

Current payment policies are complex and contradictory, and often work *against* efforts to improve quality.

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Barriers to Quality Inherent in Payment Policies

Example 1

Improved management of diabetic patients through frequent e-mail communication can produce better outcomes and fewer visits, and *lower* physician group revenues under FFS payment.

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Barriers to Quality Inherent in Payment Policies

Example 2

Through more improved choice of initial antibiotics to treat pneumonia, a group of mid-west hospitals decreased complications, mortality rates and hospital days and costs. Hospital revenues also *decreased* as patients shifted from higher paying to lower paying DRGs.

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Payment

- Purchasers should examine their current payment methods to remove barriers that impede quality improvement, and to build in stronger incentives for quality enhancement
- HCFA and AHRQ should identify and evaluate various options for better aligning current payment methods with quality improvement goals

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Payment Methods: Guiding Principles

Payment methods should

- provide fair payment for good management of the types of patients seen
- provide an opportunity for providers to share in the benefits of quality improvement
- provide an opportunity for consumers and purchasers to recognize quality differences and make decisions accordingly



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Payment Methods: Guiding Principles

Payment methods should

- align financial incentives with the implementation of care processes based on best practices
- reduce fragmentation of care

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Aligning Environmental Forces

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Applying Evidence to Health Care Delivery

Focusing on priority conditions, a public - private partnership should:

- synthesize evidence
- identify best practices in care delivery
- communicate evidence to public and professionals
- develop and apply decision support tools
- establish goals for improvement in care processes and outcomes
- develop core sets of quality measures

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Aligning Environmental Forces

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Preparing the Workforce

- Health care is not just another service industry. The people who deliver care are the system's most important resource.
- Over the coming decade, the nature of work will change dramatically--new types of work, new types of organizations and settings, new multidisciplinary relationships, and new patient and clinician relationships.

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Preparing the Workforce

A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for

- restructuring clinical education at all levels
- assessing the implications of change for credentialing programs

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Summary

American health care is beset by serious problems, but they are not intractable. The committee envisions a system that uses the best knowledge, that is focused intensely on patients, and that works across health care providers and settings. Achieving this ideal will require crossing a large chasm between today's system and the possibilities of tomorrow.