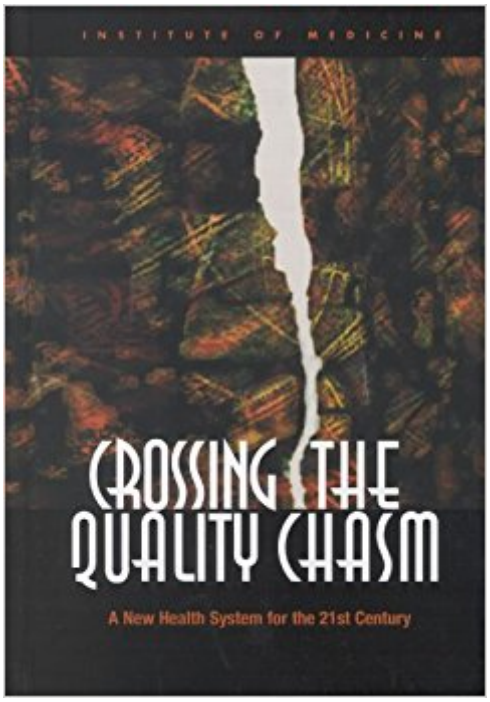
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Crossing The Quality Chasm: A New Health System For The 21st Century



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Synopsis

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

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Customer Reviews

The Institute of Medicine's Committee on Quality of Health Care in America has issued its second and final report, Crossing the Quality Chasm: A New Health System for the 21st Century. The committee has done an excellent job, but its report is as noteworthy for what it omits as for what it

says. It identifies and analyzes with great insight and clarity deficiencies in the quality of our present medical care delivery system, and it is persuasive in outlining how the system ought to work. But it does not say much about the fundamental causes of those deficiencies. Nor does it address the central question: Can we really ``cross the quality chasm'' in medical care without major reform of the whole system? The committee's earlier report, To Err Is Human: Building a Safer Health System (Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 1999), was released in the fall of 1999. The report created an immediate sensation with its estimate of 44,000 to 98,000 deaths annually due to errors in hospital care, which it said were due more to error-prone institutional systems than to mistakes by individual health care workers. Predictably, the report launched a spate of governmental and private projects to study the cause and reporting of such events and the means of preventing them. The committee's second report moves beyond the initial focus on medical mishaps and takes a broader look at other problems with the quality of health care. It suggests, in general terms, a variety of ways in which the effectiveness and efficiency of health care should be improved. The report is thoughtful, painstaking, and totally reasonable, and yet it has attracted much less attention than its predecessor. Why hasn't Crossing the Quality Chasm had more impact? I think there are several reasons. First, it contains nothing nearly so sensational as the claim made in the first report that tens of thousands of deaths are caused by medical errors. Second, most of the problems in our health care system that are identified in the second report have been widely recognized for some time. For example, as important causes of reduced quality, the report cites fragmentation of responsibility and lack of continuity in the care of individual patients. It describes the lack of coordination and communication among providers and between providers and patients. And it faults the system for not sufficiently employing electronic-information technology. It criticizes the system's failure to rely on evidence-based guidelines as standards for practice and faults providers for failing systematically to record and report outcomes. It also finds the current health care delivery system insufficiently responsive to the needs of patients and not sufficiently accountable to payers or patients. All these problems are certainly important. But they have been described before, and this report offers little that is substantive in the way of new and practical ways to solve them. This omission is probably the chief reason for the lukewarm reception given this study. Granted, the study calls for greater attention to the need for improving the quality of care. It calls for workshops, more research and education, a reexamination of current payment methods, and many other general initiatives of this kind. It urges Congress to establish a ``Health Care Quality Innovation Fund'' to support projects on the improvement of quality, and it estimates that something ``on the order of $1 billion over 3 to 5

years'' would be needed. The report also suggests that the Agency for Healthcare Research and Quality should identify ``not fewer than 15 priority conditions'' and should convene a meeting to ``develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years for each of the priority conditions.'' But these recommendations, however well intended, do not go to the heart of the matter, and they offer little in the way of fundamental solutions. In fairness to the committee's meticulous and scholarly work, I should acknowledge that it did not set out to ``recommend specific organizational approaches to achieve the aims set forth.'' The committee was no doubt asked instead to concentrate on general aims, to suggest principles and guidelines for improving the quality of care, rather than confront the controversies that would result from suggesting basic reforms in the organization of the health system. So, what is wrong with the organization of our present health care system that accounts for its problems with quality? In my view, the central problem is that the system is being directed mainly by market forces, which are as ill suited to the achievement of the quality goals envisioned in this report as they are to the attainment of the equally important goals of cost control and universal access. The notion that health care is basically an economic commodity represents a radical change from earlier assumptions about the social purpose of health care. It has gained currency only during the past 10 to 20 years, but it has already produced public policies that are rapidly converting our health care system into a vast competitive marketplace. We now have a large and growing sector of health care delivery controlled by private business, to a degree unmatched in any other nation. As is the case with other markets in the U.S. economy, the part of medical service that is privately insured is distributed primarily according to the ability to pay. The multiple independent private insurers (mostly investor-owned) constantly seek to reduce their payments to providers and their financial obligations to sick patients. Similar economic pressures and incentives are at work in the governmental half of the system. In all parts of the system, the providers of care (i.e., hospitals and physicians) see themselves as competing businesses struggling to survive in a hostile economic climate, and they act accordingly. The predictable result is a fragmented, inefficient, and expensive system that neglects those who cannot pay, scrimps on the support of public health services and medical education, and has all of the deficiencies in quality that are so well described and analyzed in this report. It is a system that responds more to the financial interests of investors, managers, and employers than to the medical needs of patients. The best way to achieve substantial improvements in the quality of care, I believe, would be to change the system. Unfortunately, the committee does not say that. It concentrates instead on suggestions for modifying behavior in the current system. However, the prospects for persuading participants caught up in the present

commercially dominated system to behave in a more socially responsible way are not very good. I suspect most members of the committee know that but that they felt constrained by the terms of their charge to focus on incremental improvements in the quality of the present system. Given those constraints, they have done all that could have been expected, and they have done it very well. A more definitive approach to the problems they address must await major reforms in the health care system. Arnold S. Relman, M.D. Copyright Ã Â© 2001 Massachusetts Medical Society. All rights reserved. The New England Journal of Medicine is a registered trademark of the MMS.

"...Committee’s strong findings and bold vision will give new momentum to the processes of change in American health care." -- Institute for Healthcare Improvement website

The IOH, Institute of Health, published two exhaustive reports on healthcare: To Err is Human and Crossing the Quality Chasm. They are dry, academic, ponderous and difficult to read. However they are two of the most important books written about healthcare in the United States and mandatory reading for anyone in the field of medicine. Virtually every other book on improving healthcare quotes or uses the research from these two books.Healthcare is under a radical transformation based on enormous economic and demand pressures. In order to be successful we have to understand the system, warts and all. We have to have solutions based on empirical peer reviewed data. These IOH reports do just that. While they may seem dated and many of the initiatives advocated by these books are well underway, these books remain 'bibles' of a sort for understanding the US medical system. I strongly recommend reading this books because so much of the current reform, language, and subsequent published literature is based on these two reports.I recently attended a training by Intermountain Healthcare in UT - the hospital system discussed during the election debates. The CFO quoted from these books. That is just one illustration of how influential and important these books are. Even if you don't work in medicine these books will help you manage and direct your own care. Read also "Overtreated" by Shannon Brownlee, which also uses IOH data and research.Not easy reads but few important reads are.

The original book for healthcare reform! Tracks Institute of Medicine (IOM)'s diagnosis of root causes of healthcare costs and inffectiveness. Summarizes the results of workshops in which the best minds in healthcare, computer sciences and policy come together to understand and observe various dimensions of healthcare and its problems. Addressing root causes always better than addressing symptoms. That's what this book represents!

This book is written as the product of an Institute of Medicine initiative to reduce the mortality and morbidity from errors in the American healthcare system. The Institute of Medicine is a private organization created by congressional charter to advise the federal government on specific matters. Their mission statement is to "advance and disseminate knowledge to improve human health." This book is the final report of the Committee on the Quality of Health Care in America. Their homepage is available by searching the Internet using the full committee name. Membership of the committee and sponsors of the project are available at that web site.The format of the book is to present evidence for quality problems in healthcare in America and make recommendations. The operational definition of quality used in the book is "The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." There are thirteen recommendations presented initially and are discussed in relevant chapters. The recommendations vary in scope from suggesting that multiple parties need to be committed to quality as a way to decrease the burden of disease to suggestions that specific agencies fund pilot studies to look at how reimbursement can be aligned with quality. Six major parameters are discussed as guiding quality and it is suggested that 15 specific conditions be a focus for improving quality.There is no difficulty in identifying literature studies that demonstrate quality problems in hospital and clinical populations. A survey of current research is included in Appendix A. A review of the tables in this appendix show the types of quality markers that are typically studied in the literature. The authors make the argument that errors due to quality lapses or deficiencies need to be actively worked on and that the current high error rates are not acceptable. Health care has become a major political issue and the political factions are shaping up to be government and business on one side and physicians and other health care providers on the other. There has been a major revamping of the health care system in the past decade to control costs. That required the active cooperation of the insurance industry and government. There is still medical inflation and limited access with 40 million Americans uninsured. Should we believe that another cooperative effort between industry and government will improve quality any more than it has controlled cost or improved access?The authors acknowledge weaknesses in their suggestions about changing the face of American medicine, but they minimize the adverse impact of the current funding mechanisms for medical care and the issue of information systems integration and security. A good example can be found in their application of engineering principles to clinical settings - - where teams see patients for four hours of direct contact time and the remaining time is for documentation and returning calls. That plan would not be economically feasible in many

settings. The high cost and lack of flexibility of the current reimbursement schemes are not mentioned as a potential reason why these plans won't work.Information technology is seen as a way to enhance both productivity and safety. The authors suggest that e-mail can lead to productive exchanges between physicians and patients. Many physicians have been doing this for years. Many have also stopped with the advent of security concerns about medical privacy. With larger IT systems the critical issue is backward compatability with older systems. That usually requires custom designs that are extremely expensive. Those problems usually need to be solved before bedside computing and decision support can be developed. Security is acknowledged as a problem that needs to be solved. In spite of a federal initiative in this area, the important precedent to remember is how the financial privacy of Americans was protected. The authors point out that medical privacy requirements need to be more stringent than other industries. At the same time they point out that some opinions suggest that there is a trade off between privacy protections and the need to advance information technology in health care. If they are suggesting that the Internet should be at the heart of this infrastructure and the Internet is not secure, what does that mean?A practical approach might be to focus on the areas where data is entered into computer systems and make sure that non-human analysis occurs at those levels. For example, all hospitals enter pharmacy orders into computer systems. Many hospitals require that physicians write separate discharge orders. Both of these points are areas where there could be immediate improvements in accuracy. A focused study and solution could be engineered now. The necessary software and hardware requirements could be placed on a central web site and available for download by hospital and clinic IT staff. Existing reviewers could be charged with documenting the baseline level of errors and the degree of improvement.This book succeeds as a broad survey of what has been done about quality in certain settings. It contains some interesting ideas about what can possibly be accomplished by applying conceptual advances from other fields. It does not discuss the significant drawbacks of evidence based medicine. It lacks a practical plan for transitioning to a new system and in effect creates a new chasm. With a work like this, whether you like the conclusions depends a lot on your interpretation of the evidence and your personal experience. As a practicing physician and a previous quality reviewer I have significant areas of disagreement with what is presented in this book. Areas of controversy are not elaborated upon. I suppose you could say that level of analysis is not required, but recommendations about the future of health care in America should at least meet the criteria of "evidence based" and all the evidence should be discussed.George Dawson, MD

good reference book. Delivered as promised and on time.

Great reference for anyone interested in quality in our health care system. it is unfortunate that many of the policy makers haven't really read this and digested what the lessons were. It was written a decade ago and we are still struggling with recommendations that were made then. I would recommend this to anyone interested in this topic.

Very Happy!

Not what I expected. Old information.

THE BOOK WAS OK, BUT I DIDN'T KNOW IT WAS DOWNLOADABLE FOR FREE ON THE IHI SITE. UGH.

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