About that quality chasm

10 years after IOM report, authors see progress, but ...

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Posted: February 21, 2011 - 12:01 am ET

It's been 10 years since the Committee on Quality of Health Care in America released its second and final report, Crossing the Quality Chasm: A New Health System for the 21st Century. Many of the report's key terms—"evidence-based," "patient-centered," "transparent"—now form the language commonly used to talk about healthcare quality in everything from government-led improvement initiatives to hospital marketing materials.

But it wasn't always that way, according to committee members.

While many of those who helped to write the report acknowledge that progress has faltered in some areas, they say the biggest achievement of Crossing the Quality Chasm—and of its companion report, the landmark To Err is Human: Building a Safer Health System, released two years earlier—is that the two efforts combined changed the mindset of an industry.

"It provided a jolt to the field," says Dr. Mark Chassin, who was a member of the committee and is currently president of the Joint Commission, a not-for-profit healthcare accreditation organization. "It elevated the recognition that these problems of overuse, underuse and misuse were quite widespread, and no organization, no matter how well-known, was immune from them. Ten years later, there are few if any leaders who would say, 'Not in my organization. These are someone else's problems.' Just a decade ago, it was a drastically different environment."

William Richardson, president emeritus of Johns Hopkins University, chaired the committee and agrees that the report prompted a seismic shift in attitudes.

"Obviously, if you look at progress, we still have a long way to go," Richardson says. "But the level of reservation has gone way down and the awareness and acceptance of the report's recommendations has gone way up."
Appointed by the Institute of Medicine in 1998, committee members were charged with outlining strategies for improving healthcare delivery, exploring new payment models, reducing variation and lowering the likelihood of errors.

"Healthcare has safety and quality problems because it relies on outmoded systems of work," they stated in the report. "Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes."

A road map for change

The committee’s 19-member roster included prominent healthcare policy experts, including Dr. Donald Berwick, founder and then-president of the Institute for Healthcare Improvement, who now serves as CMS administrator; Lucian Leape, adjunct professor at the Harvard School of Public Health and chairman of the Lucian Leape Institute; and Mary Wakefield, current administrator of HHS' Health Resources and Services Administration.

Members laid out an agenda that featured six aims for healthcare—that it should be safe, effective, patient-centered, timely, efficient and equitable—as well as detailed lists of rules and recommendations to be used to redesign care. For instance, the committee recommended aligning payment policies to spur quality improvement, a practice that has been attempted in small-scale pilots and private-payer initiatives and is now being rolled out on a larger scale by the CMS.

Those strategies, according to Janet Corrigan, president and CEO of the National Quality Forum, are what differentiated the Crossing the Quality Chasm report from the committee's earlier report on safety.

"To Err is Human was a wake-up call and it had a huge communications impact," says Corrigan, who served as director of IOM's healthcare quality project staff, which oversaw production of the two reports. "But Crossing the Quality Chasm was more of a road map for fundamental change of the system. Indeed, for us to address the problems in the original report, we needed to go down that road."

Corrigan echoes Chassin's view that the quality report helped to change the mindset of those in the healthcare system and put performance improvement high on the priority list.
That shift, she says, has paved the way for improvements, including the development of quality measures and increasing adoption of health information technology, bolstered by the healthcare IT provisions of the federal stimulus law.

Other steps in the right direction have included the launch of Hospital Compare, the CMS' quality information website for consumers, and hospitals' use of process-improvement tools such as Lean and Six Sigma, says Dr. Robert Wachter, professor and chief of the division of hospital medicine at the University of California at San Francisco.

And with last year's passage of the Patient Protection and Affordable Care Act, many of those early efforts will be rolled out on a much larger scale, says Wachter, who has written extensively on quality improvement and patient safety.

“To have accomplished that much in a decade is fairly impressive,” Wachter says. “If you had asked me how quickly we would evolve, I would not have guessed we’d have done as much as we have.”

One of the largest drivers of system improvement in the healthcare reform law will likely be the Center for Medicare and Medicaid Innovation, the committee members say. The center, which began operations in January, will test new models of care that have the potential to curb costs and enhance quality. The center is important because it addresses the question of how to improve quality while allowing for differences across communities and delivery systems, Chassin says.

“Setting up payment incentives and targets is important, but the biggest challenge for healthcare organizations is figuring out how to reach those goals we are all aiming for,” Chassin says. He also points to the Joint Commission's Targeted Solutions Tool, a Web-based resource that offers tested improvement tips and strategies to all accredited hospitals. Chassin says the site has attracted more than 25,000 visitors since it went live five months ago.

The Affordable Care Act will also address healthcare inequality, one of the central aims of the report, says Arthur Levin, who served as a member of the committee and is director of the not-for-profit Center for Medical Consumers.

**Stubborn problems**

Despite gains, however, progress in other areas has been glacially slow. The system still has a long way to go before it can really be called patient-centered, Levin says, and comparative-effectiveness research has lagged far behind where it needs to be.

Rates of preventable harm have also stayed stubbornly high despite widespread efforts to address them. In a November study in the *New England Journal of Medicine*, researchers led by Dr. Christopher Landrigan, director of the Sleep and Patient Safety Program at Brigham and Women's Hospital, Boston, found little evidence of improvement in rates of
patient harm in North Carolina hospitals during a six-year period.

There are reasons why preventable harm has been difficult to address, Chassin says, including the increased vulnerability of patients with complex conditions, but progress has been nonetheless inadequate, he adds.

Workforce preparation has also fallen far short of original goals, committee members say. The *Crossing the Quality Chasm* report stressed the urgent need for a redesign of “the way health professionals are trained.”

But a decade later, most physicians and nurses are still educated in silos, making it difficult to later work in a nonhierarchical, team-based culture, says Sam Watson, senior vice president for patient safety and quality at the Michigan Health & Hospital Association and executive director of the MHA Keystone Center for Patient Safety & Quality, the association’s safety and quality-improvement organization.

“I'm seeing some pockets where there is movement toward workforce training,” Watson says. “There are a few medical schools and nursing schools that are actually putting students together, but it is a long way from where it needs to be. And we also need to address the issue that occurs when residents enter their programs and find an old guard of physicians who might not support that team culture.”

Also, more work needs to be done to ensure the quality measures used for public reporting and payment programs are the right measures, Wachter says. He estimates that the publicly accessible quality measures currently available reflect only about 10% of the issues affecting quality of care. Measures don’t assess whether physicians are accurately diagnosing conditions, they don’t touch on a huge number of conditions, and they don’t address patients with multiple comorbidities, he says.

“It’s no one’s fault,” Wachter says. “We're just not very far along in the science of measuring quality for complex, real-world patients whose conditions have a lot of overlap. We've made baby steps.”

In spite of the difficulties, those who helped craft *Crossing the Quality Chasm* say they are hopeful about upcoming improvements in the next decade.

The NQF’s Corrigan says the system is “on the precipice of a real transformation,” which she says will be fueled by improvements in health information infrastructure and evidence-based medicine.

“I am optimistic because in the last 10 years, we achieved a much higher level of agreement about the goals and how to achieve them,” says David Lansky, president and CEO of the Pacific Business Group on Health. Lansky was one of the reviewers of the report. “Maybe the last 10 years was a necessary time of preparation, but in the next decade, I hope we can get on with it.”