Addressing the Quality Chasm for a New Health System in the 21st Century

By J. Lyle Bootman, PhD, and Daniel D. Von Hoff, MD

In November, 1999, a report entitled "To Err is Human: Building a Safer Health System" was released by the Institute of Medicine (IOM). The first in a series of reports published as part of the Quality of Health Care in America Project, the report stated that more people die from medical mistakes each year than from highway accidents, breast cancer, or AIDS. Furthermore, the report suggested that this was only the tip of the iceberg in the larger story about quality in America's healthcare system. They illustrated that health care was organized in an overly complicated system that often wastes resources by providing unnecessary services, duplicating efforts, leaving gaps in care, and failing to build on the strengths of all health professionals.

As you may have read, the most recent and final report from the Quality of Health Care in America Project IOM subcommittee was released March 1, 2001, and is entitled "Crossing the Quality Chasm: A New Health System for the 21st Century." As stated by William C. Richardson, chair of the committee that wrote the report and president of the W. K. Kellogg Foundation,

> "…the system is failing because it is poorly designed for even the most common conditions such as breast cancer and diabetes. There are very few programs that use multi-disciplinary teams to provide comprehensive services to patients. For too many patients, the healthcare system is a maze, and many do not receive the services from which they would likely benefit. Americans should be able to count on receiving care that uses the best scientific knowledge to meet their needs. But unfortunately there is strong evidence that this frequently is not the case."

The report goes on to say that physician groups, hospitals, and healthcare organizations work independently from one another, and too frequently neglect to communicate and utilize complete information about patients' conditions, medical histories, or treatment received in the various healthcare settings. In essence, the report provides a road map to improving health care.

This editorial provides a review of some of the key elements of this latest IOM report. The report provides a five-part agenda to building a stronger healthcare system over the next decade. The first section draws attention to the need for a strong commitment on the part of every healthcare institution and healthcare provider, purchasers and regulators to make significant improvement in six specific areas. These areas include: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity.

The report also offers a set of rules intended to make the healthcare system more responsive to patients' needs and preferences, and encourages significant participation in decision-making. These rules suggest that care should be based on a continuous healing relationship, and should be customized based on individual patient needs and values. Additionally, they further state that control should reside with the patient with regard to the necessary information and knowledge that should be shared between patient and provider, so that appropriate decisions can be made in a timely fashion. The report urges that clinical decisions should be evidence-based. In other words, the patient should receive care based upon the best available scientific evidence. Obviously, care should be safe and with minimal injury, and the healthcare industry should be more transparent. Another rule states that the healthcare system should anticipate patient needs rather than simply reacting to events, and that it should not waste resources or patient time. Finally, cooperation among clinicians needs significant improvement, in order to insure appropriate exchange of information and coordination of care.

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A most significant element of the report suggests using the 80/20 rule, which indicates that there are basically 15–20 chronic care conditions that account for more than 80% of healthcare costs, and that efforts need to be directed toward selected chronic disease states. The committee also recommended that Congress establish a healthcare quality innovation fund to support projects that could contribute to achieving the aims for improvement and can produce substantial improvements in quality for the priority conditions. Specifically, they estimate that at least $1 billion should be spent over the next 3 years to begin implementing these changes.

Another part of the committee's strategy is directed at healthcare organizations, clinicians, and patients, all of whom must now work together to redesign how care is delivered. They recommend a variety of approaches, but most importantly are those related to the use of informatics and the interdisciplinary approach to care. Health care has been relatively untouched by the revolution of information technology, and needs to be further incorporated, not only in the storing and dissemination of information, but in the actual clinical decision-making.

The report further states that methods of payment are another critical environmental force that must come into alignment with the objective of improving quality. Payment methods should encourage the implementation of care processes based upon best practice and the achievement of better patient outcomes. They strongly recommend that private and public purchasers reexamine their current payment methods to remove barriers that currently impede quality improvement, and to build stronger financial incentives for quality enhancement.

The last component of the report addresses the healthcare workforce. The authors recognize that people working in the healthcare system today are indeed the most important resource, and face many challenges as we move into the 21st century. In fact, the report suggests that healthcare workers will be required to conduct their work in a new way, and the new types of delivery organizations will use a different mix of health professionals. Implications for our academic health centers and training programs are very strong and will require a great deal of thought on how to implement the specifics in a cost-effective manner.

In summary, the report identifies the changes needed to obtain a substantial improvement in the quality of health care in America. This improvement will involve a reformation of the entire healthcare system as a whole. The environmental changes will require the interest and commitment of payers, healthcare professionals, educators, government officials, and regulatory and accrediting bodies throughout the country. Equally as important is that an improved healthcare system will include new roles and responsibility for patients and their families.

The field of caring for cancer patients (ie, oncology) is a very special field. There is a camaraderie which binds nurses, pharmacists, advocates, physicians, hospital administrators, survivors, etc. together to maximize the care of these very special patients. Since this is such a special group of people, the editors of *Oncology Spectrums*, would like to suggest that those in the oncology field provide leadership in addressing many of the concerns and suggestions offered by the two reports. We believe that in the care of cancer patients, the recommendations of the report can be implemented within this medical specialty. Obviously, many actions suggested in the most recent report will be difficult to implement without a total revamping of the healthcare system, such as payment restructuring. However, some of the actions suggested are already being addressed by selected practice sites. Leadership by the oncology field will serve to demonstrate that success can be achieved.

The implications to oncologists and those who practice in this particular specialty should become more clear as you read this report. The report is published by National Academy Press and can be purchased online at http://www.nap.edu/books/0309072808/html. We would be most interested in any questions and ideas regarding this particular topic that will continue to surface in the public media over the next year. OS

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There are two corrections to the April, 2001, editorial to note. The melanoma study referred to on page 227 was incorrectly attributed to Hedenfalk and colleagues. The correct authors are Duggan and colleagues. The corresponding reference (7) should read: Bittner M, Meltzer P, Chen Y et al. Molecular classification of cutaneous malignant melanoma by gene expression profiling. ***Nature***. 2000;406:536-540.