

Crossing The Quality Chasm, A New Health Care System For The 21<sup>st</sup> Century  
An Overview

In March 2001, The Institute of Medicine (IOM), which was established by the National Academy of Sciences in 1970, published a Report entitled Crossing The Quality Chasm, A New Health Care System For The 21<sup>st</sup> Century. The Renal Physicians Association (RPA) Board of Directors extensively reviewed this publication and its implications for the delivery of quality patient care at its January 2002 Board meeting. Crossing The Quality Chasm sets goals for a major overhaul of our health care delivery system which may serve as a blueprint for changes to come. To obtain more information about the Report, visit the IOM's website, [www.iom.edu](http://www.iom.edu).

Crossing the Quality Chasm calls for “fundamental change(s)” in our health care system consequent to various current problems: there is universal “frustration” by practitioners, patients, insurers, employers and hospitals with the present system; there is frequent, unintended harm by the system; there is an inherent failure to proactively address cost and quality concerns; medical scientific and technological advances have outpaced health care delivery innovations; and there has been a fundamental shift in the way medicine is practiced in the United States, from acute care to chronic care. The failure to adequately consider chronic illness, including chronic kidney disease (CKD) and end-stage renal disease (ESRD), has vast implications as the American populace ages. Currently 40% of the US population has more than one chronic medical condition. Chronic illness accounts for the majority of health care expenditures, including the cost of greatest concern to consumers -- medication expenditures.

The goals for the new health care delivery system are enumerated in the Report. These are not all theoretical. Many of these goals are already in practice or in development for implementation soon.

1. A new system must be **evidence based**. Evidence based medicine (EBM) is defined as the “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. Evidence based medicine requires the integration of scientific literature with clinical expertise and patient values.” Although scientific literature is the centerpiece of EBM, it does not exclude clinical expertise [N.B. “expertise” includes but is not limited to “experience and training”]. Importantly, EBM requires consideration of patient values in the decision making process. The theme of patient values and preferences recurs throughout the IOM's Report and will be described in more detail under the 6 aims of health care quality.
2. The Report also calls for a new system that is driven by **quality** in all aspects. The I.O.M. defines quality as “the degree to which health services for individuals and populations increase the likelihood of improved outcomes and are consistent with current, professional knowledge.” Therefore quality health care services are quantified by outcomes measurement and kept current by intermittent review of professional knowledge.

3. The Report also calls for a **systems oriented** approach to health care delivery. A system integrates a purpose or goal with all of the necessary parts involved in producing that goal.

The Report sets 6 goals for quality in health care as benchmarks to judge current and new delivery system policies; safety, effectiveness, patient centeredness, timeliness, efficiency and equity. These 6 aims can be remembered by the simple neumonic, “**SEPT E<sup>2</sup>**.” *RPA has demonstrated expertise and commitment to these goals.*

1. **Safety** means avoiding injury, or in “patient safety” parlance, avoiding misuse of health care. *The RPA is furthering this goal via its partnership in the National ESRD Patient Safety Initiative, which is developing patient safety taxonomy, best practices, and patient safety education for the renal community.*
2. **Effective** health care provides care to those who will most likely benefit and withholds care from those who will not likely benefit (avoiding “under use” and “overuse”). *The RPA advances this goal with its guideline, Shared Decision Making in the Appropriate Initiation and Withdrawal from Dialysis.*
3. **Patient centeredness** refers to the consideration of patient preferences and values in all health care delivery. It implies that patients and their families should be at the “center of decision making”, thereby requiring health care providers to educate patients so that their decisions may be informed. This is a centerpiece theme of the Report and has been embraced by many patient consumer organizations. *The RPA advances this goal with its guideline, Shared Decision Making in the Appropriate Initiation and Withdrawal from Dialysis.*
4. Health care should be administered in a **timely** fashion, neither too soon nor too late. Waits should be reduced and harmful delays eliminated. *RPA is currently developing a guideline concerning patient preparation for renal replacement therapy, which will include statements pertaining to the timeliness of therapeutic interventions in patients with GFR < 30 ml/min. In addition, RPA’s position paper on Managed Care addresses this principle.*
5. Health care should also be administered in an **efficient** fashion by which the Report calls for the proactive avoidance of waste of time (including the patient’s), material, energy, equipment and ideas. *RPA’s Managed Care position paper describes efficient nephrology practice models.*
6. **Equity** in health care means there is an attempt to prevent variation in quality due to geographic location, gender, ethnicity, race, status, or gender. The Report repeatedly suggests that the only excusable variation in quality is patient preference.

As a result of the dissatisfaction with our present health care system, the Report calls for a fundamental change in current health care “rules”. The proposed “new rules” present some of the most challenging propositions of the Report. However, **some of these changes are already evolving in today’s clinical practice.** Other “new rules” are in direct conflict with

current existing regulatory and reimbursement regulations. **Subsequent chapters of the Report propose regulatory and other “environmental” changes which must occur before or coincident with these proposed rule changes.** The rule changes are as follows:

1. Whereas current health care delivery occurs during face to face episodes, the Report calls for a new system which can **provide care 24 hours per day, 7 days per week**. Many practices today are systematizing “same day appointments” and “24/7” patient accessibility. *RPA has partnered with Medem to provide interactive and clinically functional, personalized websites to RPA members. More information on interactive, personalized nephrology websites can be obtained on the RPA website, [www.renalmd.org](http://www.renalmd.org).* This “rule change” is rapidly evolving from the theoretical to the practical.
2. The only acceptable variation in care should be due to **patient preference**, rather than professional preference.
3. Currently professionals control care; the Report calls for **patients as the source of control**. *RPA’s guideline, Shared Decision Making in the Appropriate Initiation and Withdrawal from Dialysis demonstrates patient centeredness in nephrology practice.*
4. Rather than information being contained in a written record, the Report proposes that **information be shared and flow freely**.
5. Currently, health care decisions are based on training and experience; the Report calls for **evidence based decision making**. *Each of RPA’s guidelines has been evidenced based; the most recent guideline undertaking utilizes an independent, Evidence Practice Center thereby eliminating potential reviewer bias in literature selection and rating.*
6. Rather than safety being an individual responsibility, the Report states that **safety should be considered as a system** and built into all policies. *The RPA’s leadership in the National ESRD Patient Safety Initiative demonstrates adherence to this rule change.*
7. Currently, cost reduction is reactive whereas the Reports suggest that it be proactive and continuously reassessed.
8. The Report characterizes the current health care delivery system as various small areas of influence determined by professionals, but instead calls for a system where **improved cooperation among clinicians** results in better team management across various venues and conditions for patient care, thereby blurring “who can do what to whom.” *RPA’s White Paper on the Use of Disease Management in ESRD Care illustrates the potential application of this rule to nephrology practice.*

Some of these changes are daunting and it is not surprising that upon first exposure many knowledgeable professionals label much of the aforementioned impossible at best, absurd at worst. *However, many RPA initiatives demonstrate that several of these aims and rules are worthwhile and achievable.* Recognizing the revolutionary nature of these changes, the Report proceeds to suggest required first and subsequent steps to allow change, building organizational support for change and finally the establishment of a new environment for

care. The Report provides thirteen recommendations to achieve the goals and rule changes. Six of the thirteen recommendations concern the establishment of a new environment.

The required environmental and organization changes call for improved use of: **information technology**; utilization of **multidisciplinary teams** who can coordinate care across services and settings; **guidelines** in clinical practice; and **performance and outcome measures** to improve quality and accountability.

Enhanced **information technology and infrastructure** should improve the clinical application of **evidence based medicine**. Technology should provide rapid and timely (“**point of care**”, “**point of contact**”) access to specific best practice guidelines and other evidence based information (e.g., drug dosage plus contraindications and interactions information at the time of prescribing), obviating the need for memory dependence (which is fallible, dependent upon such factors as sleep preceding its use). Many of the subsequent recommendations are already in practice in some parts of the country. The Report recommends that information technology applied to clinical care include use of **patient accessible email and practice websites, telemedicine, online prescribing, and “point of care” decision support systems** (like clinical PDA applications, automated orders, and clinical progress notes imbedded with popup guides and reminders). *The RPA website, [www.renalmd.org](http://www.renalmd.org), offers to RPA members a professionally produced individualized, interactive, functional and dynamic nephrology practice website without charge. The website also contains downloadable PDA applications to assist with “point of contact” decision making.* The Report calls for an information infrastructure that supports quality improvement, research, education, and accountability. The Report calls for the elimination of hand written clinical data by the end of this decade! These recommendations are rapidly becoming more practical and less theoretical.

The Report recognizes that present **reimbursement methods** present significant barriers to change. For example, fee-for-service can inhibit preventive medicine. Capitation and salary reimbursement methods can produce underutilization of effort and adverse risk selection (“**cherry picking**”). The Report calls for study of innovative reimbursement methods that enhance quality. Medicare could develop RVUs (relative value units) for providing care for a pre-selected list of **high priority medical conditions** (Those medical conditions which comprise the majority of health care expenditures due to chronic illness and debilitation, as determined by The Agency for Health Care Research and Quality; e.g., cancer, diabetes, emphysema, high cholesterol, hypertension, ischemic heart disease, stroke). Additional suggestions for study include new CPT coding for **non-face-to-face interventions** (e.g., email and telemedicine), coordination of care (e.g., by multidisciplinary teams), research, and relevant clinical updates. The Report recommends that current capitated systems reward “**best practice utilization**” rather than outcomes. Too much emphasis on outcomes can lead to “cherry picking” or “system gaming”, whereas rewarding “best practice utilization” employs evidence based medicine and guideline use with a systems orientation. Clinical outcomes should improve by applying best practices, excepting those outcomes adversely affected by patient preference (e.g., patients who prefer to shorten their dialysis time against medical advice), which the Report notes is an allowable exception (see “patient centered care” above). *RPA’s Health Care Payment Committee is developing a position paper on Performance-Based Physician Incentives for improved quality patient care.*

Another important required environmental change concerns **medical education**. Unlike traditional clinical education which teaches a core of knowledge focused on basic mechanisms of disease, the Reports recommends that medical education teach evidence based best practices, systems approach to safety, utilization of new information technologies, and the concept of collaborative management (multidisciplinary care teams with patient centered care).

The Report also calls for changes in **licensure and professional scope of work** to improve standardization across professional organizations and geography. *The Renal Physicians Association supports these changes, with nephrologists as leaders of the renal health care team.* It calls for study of innovative ways to change **regulations and tort law** to facilitate multidisciplinary care teams, the use of new technologies, and deployment of health care professionals. The Report recognizes that **traditional medical malpractice** inhibits the free flow and “transparency” of information. Tort law impairs reporting of adverse events and “near misses”, inhibiting the development of a systems approach to patient safety. The Report recommends “no fault” liability insurance and litigation based on evidence based clinical practice guidelines rather than expert testimony.

*RPA recognizes the challenges associated with implementation of these recommendations. RPA projects already embrace many of the Reports recommendations.* The recommendations, although in their infancy, are rapidly being employed. The 6 aims of quality (“SEPT E<sup>2</sup>”) in health care and the proposed rule changes can provide a **useful template against which to compare our own practices’ policies and procedures**. The Report provides a road map and taxonomy for change.

It is worth noting that Arnold Relman in a New England Journal of Medicine (345:702-703, 2001) book review of Crossing The Quality Chasm states “the Report is as noteworthy for what it omits as for what it says.” Relman asks, “Can we really “cross the quality chasm” in medical care without major reform of the whole system, [which is] directed mainly by market forces... respond[ing] more to [the] financial interests of investors, managers, and employees than to the medical needs of patients.” He concludes, “The best way to achieve substantial improvement in the quality of care ... would be to change the [entire] system.”