

## Free Executive Summary

### 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities



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Editors, Committee on the Crossing the Quality Chasm:  
Next Steps Toward a New Health Care System

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## Executive Summary

### ABSTRACT

On January 6 and 7, 2004, the Institute of Medicine (IOM) hosted the 1<sup>st</sup> Annual Crossing the Quality Chasm Summit, convening a group of national and community health care leaders to pool their knowledge and resources with regard to strategies for improving patient care for five common chronic illnesses. This summit was a direct outgrowth and continuation of the recommendations put forth in the 2001 IOM report *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. The summit's purpose was to offer specific guidance at both the community and national levels for overcoming the challenges to the provision of high-quality care articulated in the *Quality Chasm* report and for moving closer to achievement of the patient-centered health care system envisioned therein.

## 1ST ANNUAL CROSSING THE QUALITY CHASM SUMMIT

The Institute of Medicine's (IOM) 2001 report *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* rose out of a series of studies conducted by the IOM and others documenting serious and widespread quality problems in the nation's health care system (Chassin and Galvin, 1998; IOM, 2000; President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998; Schuster et al., 1998). Disturbing examples of *overuse* of procedures that cannot help, *underuse* of procedures known to be beneficial, and *misuse* or errors of execution of care are pervasive (Bates et al., 1995; Berwick, 2004; Leatherman and McCarthy, 2002; Wang et al., 2000; Wennberg et al., 2004). And despite more than a decade of alarming statistics, the quality of care the average American receives is still unacceptable. This observation is supported by a recent study published in the *New England Journal of Medicine* revealing that on average, Americans have just over a 50 percent chance of receiving recommended care for a host of acute and chronic conditions, as well as preventive services (McGlynn et al., 2003).

Given the magnitude and urgency of this problem, the *Quality Chasm* report called not for incremental tentative steps, but a major overhaul of the current health care delivery system. Though reforming a system as vast and complex as American health care is a daunting task, the *Quality Chasm* report distilled the principles of change into six guiding aims: health care should be *safe, effective, patient-centered, timely, efficient, and equitable* (IOM, 2001:5).

### **PRIORITY AREAS FOR FOCUSING AND IMPLEMENTING THE QUALITY CHASM VISION**

As a starting point for translating the above six aims into clinical reality, the *Quality Chasm* report recommended focusing on a set of common chronic conditions that account for the majority of the nation's health care burden and resource consumption (Druss et al., 2002, 2001;

Hoffman et al., 1996; Partnership for Prevention, 2002). In response, an IOM committee was convened to select at least 15 priority conditions for which reform strategies should be implemented. After carefully analyzing such criteria as impact on the population, potential for improvement, and inclusiveness for a broad range of individuals, health care settings, and providers, the committee identified 20 priority clinical areas for national action. These 20 areas represent the full spectrum of health care, including preventive care, acute and chronic disease management, and palliative care (IOM, 2003).

### **1<sup>ST</sup> ANNUAL CROSSING THE QUALITY CHASM SUMMIT**

The 1<sup>st</sup> Annual Crossing the Quality Chasm Summit was charged with catalyzing the transformation of the health care delivery system as delineated in the *Quality Chasm* report. A diverse committee representing a wide range of perspectives from many health care sectors was assembled to organize and lead this activity. While the committee is responsible for the overall quality and accuracy of this report as a record of what transpired at the summit, the views contained herein are not necessarily those of the committee.

In an effort to manage this enormous undertaking, the committee decided to narrow its focus to 5 of the original 20 priority areas—asthma, depression, diabetes, heart failure, and pain control in advanced cancer—with the goal that lessons learned from this initial summit would then be disseminated and further applied to the remaining 15 priority areas and beyond. The committee then identified 6 critical cross-cutting topics applicable to all of these priority areas: measurement, information and communications technology, care coordination, patient self-management support, finance, and community coalition building.

It was decided that the summit should have a community focus, as successful community innovations can provide a lens for viewing how to redesign care delivery systems, and involving community stakeholders would help mobilize the next round of quality improvement efforts. Communities can also serve as “laboratories of innovation” to assess what does and does not work before a policy is adopted nationally. Additionally, working at the community level can strengthen the interface between the personal and the population-based health systems.

Having laid this groundwork, the committee identified three objectives for the summit:

- To stimulate and further local and national quality improvement efforts, consistent with the IOM’s *Crossing the Quality Chasm* report, focusing on five priority areas—asthma, depression, diabetes, heart failure, and pain control in advanced cancer.
- To describe measurable aims and appropriate strategies for improving care in the five targeted priority areas, including endorsing performance measures necessary to assess progress over 3 to 5 years.<sup>1</sup>
- To stimulate supportive interrelationships and synergies between locally based efforts and resources at the national level, and to make highly visible the resulting commitments.

To achieve these objectives, the committee solicited the input and advice of several liaison groups, including the Centers for Disease Control and Prevention; the Institute for Healthcare Improvement; the MacColl Institute for Healthcare Innovation at Group Health Cooperative; and the Agency for Healthcare

Research and Quality. The committee also identified summit attendees who would best serve to inform and advance the *Quality Chasm* vision. More than 200 individuals participated in this event, including nationally recognized experts in the five clinical conditions and six cross-cutting areas; representatives of 15 local communities (see Box ES-1), chosen from a pool of 90 across the country; and leaders from national organizations referred to as “national champions” (see Box ES-2), which through their influence could expedite progress at the local level.<sup>2</sup> The design of the summit is unique in the IOM’s experience in that it brought together innovative local and regional providers (“doers”) and national leaders, as well as representatives of national public, voluntary, and private organizations (“environments”).

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*“Each of the communities that are participating is a building block. Each is an experimental center. Each is a place of innovation. And if we take advantage of our mutual learning in the course of this day to renew our own sense of possibility and direction then the objectives of our meeting will have been accomplished.”*

*—Harvey Fineberg, President, IOM*

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<sup>1</sup> Although performance measurement standards for each condition were called for by the participants—as noted at a number of points in this report—the summit itself did not endorse any specific performance measures for the targeted conditions.

<sup>2</sup> There are many champions of health care quality improvement around the nation. Some play on a national stage in the scope of their work, while some are regional and others are located in communities. Those listed are a number of key players who work at the national level; some of them, as well as others not listed, make an impact at the international level as well. It is hoped that others will join this list, and we emphasize that any omissions are unintentional.

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### **Box ES-1. Summit Communities**

- Asthma communities
  - Children’s Mercy Hospital/Kansas City Asthma Coalition
  - Controlling Asthma in the Richmond Metropolitan Area (CARMA)
  - The Pediatric/Adult Asthma Coalition of New Jersey
  - Philadelphia Department of Health
  
- Depression communities
  - Intermountain Health Care–Depression in Primary Care Initiative
  - Mid-America Coalition on Health Care Community Initiative on Depression
  
- Diabetes communities
  - The Asheville Project
  - County of Santa Cruz, California
  - Madigan Army Medical Center
  - The Washington State Diabetes Collaborative
  
- Heart failure communities
  - Grand Rapids Medical Education and Research Center
  - Greater Flint Health Coalition
  - The Oregon Heart Failure Project
  
- Pain control in advanced cancer communities
  - Kaiser-Bellflower
  - Rochester Health Commission

**Box ES-2. National Champions**

- Agency for Healthcare Research and Quality
- Alliance of Community Health Plans
- American Association of Retired Persons
- American Board of Internal Medicine
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Hospital Association
- American Pain Foundation
- America's Health Insurance Plans
- Blue Cross and Blue Shield Association
- Bridges to Excellence
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- General Electric Company
- Grantmakers in Health
- Institute for Healthcare Improvement
- Institute of Medicine
- Joint Commission on Accreditation of Healthcare Organizations
- Leapfrog Group
- MacColl Institute for Healthcare Innovation at Group Health Cooperative
- National Association of Community Health Centers
- National Business Coalition on Health
- National Business Group on Health
- National Cancer Institute
- National Center for Healthcare Leadership
- National Committee for Quality Assurance
- National Quality Forum
- Pacific Business Group on Health
- Substance Abuse and Mental Health Services Administration
- The Robert Wood Johnson Foundation
- UnitedHealth Group
- URAC
- VHA, Inc.

## 1ST ANNUAL CROSSING THE QUALITY CHASM SUMMIT

### SETTING THE CONTEXT FOR THE SUMMIT

In launching the summit, Reed Tuckson, chair of the IOM committee that organized this event, set the stage by positioning the patient as “true north”—serving as a compass to steer and guide health care reform efforts (Berwick, 2002). In this vein, the summit was organized to reinforce the *Quality Chasm* report’s core tenet of patient-centered health care. Patient-centered care has different meanings for each patient. For some patients it may mean care only for themselves; for others it includes both patients and their families; while for others it comprises non-professionally trained caregivers who serve as a safety net. When the “patient” is referred to in this report, the term implicitly represents this full range of circumstances.

At the summit, participants first heard from Martha Whitecotton, a registered nurse, who poignantly described the shortfalls of the current health care delivery system by relaying her family’s experiences in trying to obtain high-quality care for a child with major depression. She highlighted gaps and deficiencies in care relevant not only to depression, but to all chronic conditions. Examples included lack of a well-coordinated care plan, poor communication among multiple clinicians involved in a patient’s care, and failure to inform patients and their families about best practices. Redressing these deficiencies became the focus of the work at the summit.

Continuing on this theme during his keynote speech, Don Berwick, President of the Institute for Healthcare Improvement, reiterated the emphasis on honoring the patient—respecting patients’ preferences, needs, ethnicity, and diversity, and viewing them as the ultimate source of control. He translated the *Quality Chasm* aims from the patient’s perspective: “to have health care with no needless deaths, no needless pain or suffering, no unwanted waiting, no helplessness, and no waste” (Berwick, 2004). Embracing this approach requires not segregating patients into silos as defined by

their disease, but taking a more holistic approach to their care. The summit was deliberately structured to reflect this philosophy, emphasizing solutions that transcend any one chronic illness, in the belief that applying lessons from the core set of five priority conditions to other conditions would be expedited if the cross-cutting areas were the central focus.

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*“The ultimate judge of the quality of our work is the patient, end of story.”*

*—Don Berwick, summit keynote speaker*

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### CROSS-CUTTING SESSIONS

The confirmed diagnosis of a broken, fragmented health care delivery system led directly to the identification of the six cross-cutting areas enumerated above. These areas largely reflect those discussed in the *Quality Chasm* series of reports, with one exception—community coalition building, added to reflect the interests and needs of summit participants from communities. The purpose of the sessions in these six areas was to identify strategies and opportunities for overcoming barriers to high-quality care, learning from communities that have made promising advances, as well as from distinguished individuals and organizations recognized as leaders in these fields. Following is a synthesis of the key strategies to be explored as identified by the summit participants (summarized in Boxes ES-3 through ES-8).

**Box ES-3. Measurement: Key Strategies**

- Integrating measurement into the delivery of care to benefit patient care
- Improving information and communications technology infrastructure to reduce the burden of data collection
- Focusing on longitudinal change in performance and patient-centered outcomes in addition to point-in-time measures
- Improving public reporting by effectively disseminating results to diverse audiences

**Measurement**

Summit participants called for national organizations, accrediting agencies, and appropriate subspecialty providers to agree on a defined, well-validated set of performance measures for the 5 chronic conditions featured at the summit, subsequently to be expanded to the other 15 priority areas. At present, clinicians collect different data for multiple parties, making the process not only overwhelming, but often infeasible in a climate of limited resources. A parsimonious set of measures would:

- Reduce redundancy and ease the load of data collection.
- Permit benchmarking and meaningful comparisons within organizations, across communities, and nationally.
- Allow for longitudinal patient-focused measures that appraise changes in health status and function over time.
- Capture community-based measures derived from actionable community-wide aims.

To create relevant measurement sets, participants advanced the idea of a matrix, with the six *Quality Chasm* aims on one axis and the priority areas on the other, whose cells would be populated with appropriate measures. They also supported public reporting of quality outcomes, including patient-centered measures of experience. Dissemination of this information must be done in a way that is meaningful and useful to different audiences.

**Box ES-4. Information and Communications Technology: Key Strategies**

- Using standardized systems
- Leveraging federal leadership to accelerate the adoption of electronic health records
- Creating a public utility that holds data at the local level

**Information and Communications Technology**

The importance of patients' access to and control of their health records was reiterated during many of the sessions at the summit. Ideally, patient health information would be stored in a transportable electronic format, easily retrieved from any computer regardless of software or system requirements. A companion goal would be for all providers' offices to have electronic health records. Both of these visions highlight the urgent need for national data standards, as transmitting health information across organizational and regional boundaries is severely stymied today by the inability of different computer systems to "talk" to each other in a common language—referred to as lack of interoperability. Accelerating the uptake of information and communications technology would involve a dual strategy of new financial incentives for clinicians from the private sector to invest in the necessary infrastructure, such as the Bridges to Excellence program (Bridges to Excellence, 2004), and federal leadership in



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promulgating national data standards (IOM, 2002a). Additionally, participants characterized health data as a public good and suggested creating a public utility that would store these data, making them accessible at the community level.

### **Box ES-5. Care Coordination: Key Strategies**

- Aligning financial incentives
- Providing educational supports, including multidisciplinary health professions education, teaching of care coordination principles in academic settings, and development of care teams
- Instituting patient-centered health records, supported by information and communications technology
- Ensuring accountability and defining roles for care

### **Care Coordination**

To address the problem of care coordination not being routinely reimbursed under most payment schemes today, participants emphasized the need for a shared vision around an operational construct—consistent with the evidence base—defining what good care coordination would be. Once operationalized, care coordination could then be measured, with the goal of quickly disseminating successful reimbursement models.

Effective management of chronic conditions requires the delivery of many services, hand-offs to other specialists, and aggressive follow-up. To address these challenges, participants suggested a two-pronged approach: (1) empowering patients and families to play a central role in the diffusion and exchange of their health information, and (2) formulating clearly defined roles for health care practitioners

and holding each team member accountable for ensuring that a patient's care is properly managed. Participants emphasized that practicing clinicians, managers, educational leaders, and current students will need preparation and guidance on care coordination principles, such as working in interdisciplinary teams, in both the didactic and clinical components of their initial and ongoing professional training.

### **Box ES-6. Patient Self-Management Support: Key Strategies**

- Identifying and disseminating evidence-based self-management practices
- Recognizing the centrality of self-management to good patient care and incorporating it into health care culture
- Developing programs and tools applicable to diverse populations
- Providing incentives for the appropriate use of self-management supports integrated into the delivery of health care
- Making better use of all members of the health care team

### **Patient Self-Management Support**

Despite the strong evidence base for many self-management practices, it is often difficult for practitioners to assess best practices or to distinguish between those that are grounded in evidence and those that are not (Bodenheimer et al., 2002; Lorig et al., 1999, 2001). Participants suggested consolidating this information and disseminating it to providers, patients, and their families through a centralized clearinghouse. Additionally, they favored aggressive expansion of the existing evidence base—both learning

from rapid-cycle practical models and, in parallel, using these experiences to inform and develop a firmer scientific base.

It was suggested that if self-management is to be recognized as an integral component of high-quality care, demand for these services must be created among clinicians and patients and incorporated into the mainstream health care culture. Barriers to widespread adoption of self-management practices include brief, rigidly scheduled office visits, which are not conducive to more labor-intensive interactions, such as completing a patient-generated action plan, and the lack of reimbursement for self-management support. Additionally, self-management programs must be flexible enough to allow for tailoring to individual patient preferences, as well as culturally, linguistically, age, gender, and lifestyle appropriate. Particular attention should be paid to health literacy and the ability to assimilate and process medical information (IOM, 2004). As with care coordination, defining roles and making more efficient use of the talents and skills of all members of the health care team are necessary, along with teaching these principles in academic and clinical settings. Families and other caregivers also need to be supported and provided adequate resources to assist patients in managing their condition.

**Box ES-7. Finance: Key Strategies**

- Instituting performance-based payment models
- Implementing evidence-based benefit design
- Providing payment for proven quality support services—care coordination and patient self-management support
- Engaging consumers with information and incentives

**Finance**

As a core strategy, participants proposed shifting to performance-based payment models that pay for performance and align incentives with evidence-based high-quality care. This approach assumes that the problem may not be one of insufficient resources, but of substantial waste and variation in the current health care system (Fisher et al., 2003a,b). Thus any changes to the present finance system would be budget neutral—redirecting and redistributing revenue streams in the many organizations that make up the larger health care system, rather than adding to the total funding for that system.

Infusing evidence-based medicine into benefit design was identified as another way to apply resources toward more effective care. For example, benefit packages could be created that would cover bundles of high-value services known to work clinically for chronic illnesses—such as HbA<sub>1c</sub> monitoring, annual eye and foot exams, lipid testing, and blood pressure control for diabetics.

The strategy of empowering consumers to modify their behavior by using monetary incentives or providing them with information important to their health was also proposed. As with all of the proposals in this area, the aim is not to simply shift costs to consumers—as is the growing trend—but instead to institute cost sharing with consumers, designed with the specific intent of encouraging them to obtain the right care at the right time. Finally, as discussed by participants addressing care coordination and self-management, reimbursement for these support services will require a shift from the current piecemeal approach of paying for individual clinician encounters to paying for elements linked to systems of care involving a team of diverse practitioners.

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### **Box ES-8. Community Coalition Building: Key Strategies**

- Determining who is going to be involved in the coalition
- Getting people to agree on a common objective and determining how to measure whether this objective has been achieved

### **Community Coalition Building**

Coalitions are organizational structures that integrate and support the work of multiple diverse stakeholders on a focused, shared goal. Input from participants prior to the summit revealed the desire for additional knowledge and skills in developing community engagement. In response, a session in this area was added to identify strategies that communities might use to establish and sustain a coalition, with particular attention to public-private partnerships and ways to gather the necessary human and financial resources. For the purposes of the summit, the aim of coalition building was identified as improving the quality and efficiency of care at the community level.

The first step in the process of activating a coalition is to ensure a proper balance among stakeholder groups—at both the community and organizational levels. Often this entails bringing together groups with competing interests. To minimize conflicts and avoid potential gridlock once the coalition has been assembled, it is critical to identify a common objective that supercedes differences in perspectives. Transparency regarding biases and conflicts of interest is paramount. Early on in the process, it is prudent to determine what issues are most important to each participant and then negotiate a workable solution that is sensitive to those concerns (Sofaer, 2003).

Once consensus has been reached around an actionable and manageable goal, the coalition must establish objectives and agree on how its impact on the community will be measured, both quantitatively and qualitatively. Care must be taken in selecting metrics that are meaningful to diverse members of the community and relevant to multiple stakeholder groups. Measurement has the dual purpose of documenting progress while also supporting a shared accountability that solidifies community cohesion and directs the rational use of coalition resources to areas of need. Documenting positive outcomes—and reasons for negative ones—helps coalitions acquire additional support and resources.

### **CONDITION-SPECIFIC ACTION PLANS**

The cross-cutting sessions helped prepare summit participants for the condition-specific work that followed. The composition of the condition-specific working groups balanced local- and national-level stakeholder groups, individuals with proficiency in the cross-cutting areas, and nationally recognized experts in the chronic conditions represented. Before the summit, the participating communities completed substantial preparatory work to identify gaps in their current care programs as compared with “ideal” evidence-based care. As a result, it was possible to minimize the time spent reviewing past accomplishments and obstacles during the summit and to focus on shared learning and collaborative problem solving.

In identifying strategies most relevant to each priority condition, participants acknowledged that for these five conditions, health care disparities persist for minority/underserved populations within communities and that addressing this issue should be a high priority (IOM, 2002b). Several overlapping strategies were proposed across the condition-specific working groups, echoing the themes that emerged during the cross-cutting sessions.

Restructuring the current finance system to reward well-integrated care and providing supports for patient self-management, for example, was a recurring topic. Information and communications technology figured prominently as an enabling tool for data collection, decision support, and improved flow of communication across providers. Measurement was a theme for all the strategies—particularly to establish short- and long-term goals. Proposals to support a patient-centered health environment ranged from research to better understand the wants and needs of patients with diabetes, to concrete actions such as ensuring that every patient has portable electronic health summaries.

Two working groups—addressing asthma and heart failure—targeted community collaborations to establish partnerships and build capacity and to create mechanisms for patients and families to take control of their chronic illness(es). Training and education on appropriate screening and treatment was a salient issue for the depression group, since depression is a major comorbidity for many chronic conditions, such as diabetes and heart failure. The heart failure group called for greater clinical engagement, focusing on the creation of methods that would make it easier for clinicians to provide efficient evidence-based care, such as dissemination of guidelines and the development and maintenance of registries. For the group addressing pain control in advanced cancer, a tactic proposed was to raise the bar on public awareness—making it inconceivable to tolerate bad cancer pain. This group expressed the need for strong coordinated leadership to “carry the ball” and convene key stakeholder groups. In addition, clinicians’ fears of legal or professional retribution for prescribing opioids—even when warranted—need to be addressed at the regulatory level.

## NEXT STEPS

The central message emerging from the 1<sup>st</sup> Annual Crossing the Quality Chasm Summit is that, despite environmental obstacles to system

redesign, some communities are making headway in the struggle to deliver health care that embodies, at least in part, the six aims set forth in the *Quality Chasm* report. Other communities can learn from and build on those experiences. The summit offered a public forum for “national champions” to step up and announce what they are willing to do to help facilitate community efforts, while also bringing national experts into the discussion to help translate local experiences to speak to a larger audience. It is hoped that the summit will be the first of many such efforts dedicated to further implementing the vision laid out in the *Quality Chasm* report.

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REPORT OF A SUMMIT

THE 1ST ANNUAL  
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Committee on the Crossing the Quality Chasm:  
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Board on Health Care Services

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*“Knowing is not enough; we must apply.  
Willing is not enough; we must do.”*

—Goethe



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<sup>1</sup> Served through January, 2004.

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<sup>3</sup> Served through December, 2003.

## Reviewers

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the NRC's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their review of this report:

**GEORGE ISHAM**, HealthPartners, Inc., Bloomington, MN  
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**LISA SIMPSON**, All Children's Hospital; University of South Florida, St. Petersburg, FL

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by **Elaine L. Larson**, Columbia University, and **Don E. Detmer**, University of Cambridge and University of Virginia. Appointed by the National Research Council and Institute of Medicine, they were responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.



## Preface

This report represents an important addition to a series of studies generated by the Institute of Medicine dedicated to improving the quality and safety of health care. It is firmly grounded in the principles articulated in *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* as a guide for the transformation of our current health care delivery system—namely the six aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

The 1<sup>st</sup> Annual Crossing the Quality Chasm Summit was convened specifically to address the redesign of the nation's currently broken health care delivery system. As recommended in the *Quality Chasm* report, the summit was focused on improving care processes for a targeted set of priority areas, in this case five common, high-burden chronic conditions: asthma, depression, diabetes, heart failure, and pain control in advanced cancer.

The summit benefited from the contributions and expertise of more than 200 local and national health care leaders who convened to collaborate on the development of strategies for improving the quality of care for individuals with these five chronic illnesses. As described in this report, significant progress is being made toward implementing the above six aims in communities across the country. It is our hope that readers will be encouraged by the support of the national champions who participated in the summit and expressed their support for efforts to facilitate the broad achievement of key strategic priorities.

The reader of this report will also appreciate how much more is required from every stakeholder in the American health care system if the goals of optimal quality and safety are to be achieved.

I am deeply appreciative of the support of our sponsor, The Robert Wood Johnson Foundation; my colleagues on the Institute of Medicine committee who helped organize and lead the summit; and all who so generously contributed their experience, judgment, and expertise to this effort.

Reed V. Tuckson, M.D.  
*Chair*  
August 2004



## Foreword

In January 2004, the Institute of Medicine (IOM) was pleased to convene the 1<sup>st</sup> Annual Crossing the Quality Chasm Summit. This was a high-energy endeavor designed to move us closer to realizing the vision for the nation's health care system described in the 2001 IOM report *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. That report called for fundamental redesign of the current system. To begin this transformation, the report recommended focusing on a set of priority conditions, taking into account frequency, burden, and resource use. A subsequent IOM report, *Priority Areas for National Action: Transforming Health Care Quality* identified 20 such areas, 5 of which—asthma, depression, diabetes, heart failure, and pain control in advanced cancer—were initially targeted for the summit's work.

At the summit, representatives of innovative communities from across the country joined forces with national leaders and organizations to identify strategies for achieving high-quality care for patients burdened with these five chronic illnesses. The synergy between local and national leaders at the summit was strong, and the strategies put forth are actionable now. The essential goal is to close the gap between what we know to be best practice and how care is routinely delivered today.

Although much work remains to achieve the kind of fundamental change called for in the *Quality Chasm* report, it is apparent that we are well on our way. I applaud the communities and national champions who participated in the summit for their creative approaches and their dedication to improving the quality and safety of health care for all Americans.

Harvey V. Fineberg, M.D., Ph.D.  
*President, Institute of Medicine*  
August 2004





## Acknowledgments

The Committee on the Crossing the Quality Chasm Summit wishes to acknowledge the many people whose contributions made this report possible. We appreciate how willingly and generously these individuals contributed their time and expertise to assist the committee.

**The committee benefited from the knowledge and input of members of the liaison panel:** Brian Austin, MacColl Institute for Health Care Innovation at Group Health Cooperative; Donald M Berwick, Institute for Healthcare Improvement; Maureen Bisognano, Institute for Healthcare Improvement; Carolyn M. Clancy, Agency for Healthcare Research and Quality; Lisa M. Koonin, Centers for Disease Control and Prevention; Dan Stryer, Agency for Healthcare Research and Quality; Ed Wagner, MacColl Institute for Health Care Innovation at Group Health Cooperative; and Stephanie Zaza, Centers for Disease Control and Prevention.

**Presenters and panelists helped inform and enlighten summit participants:** Donald M. Berwick, Institute for Healthcare Improvement; William L. Bruning, Mid-America Coalition on Health Care Community Initiative on Depression; Albert D. Charbonneau, Rochester Health Commission; Helen Darling, President, National Business Group on Health; Jack C. Ebeler, Alliance of Community Health Plans; Harvey V. Fineberg, Institute of Medicine; Henry Gaines, United Automobile Workers/General Motors Community Health Initiatives; George J. Isham, HealthPartners, Inc.; Sylvia Drew Ivie, The Help Everyone Clinic, Inc.; John Lumpkin, The Robert Wood Johnson Foundation; Jay M. Portnoy, Children's Mercy Hospital; and Martha Whitecotton, Carolinas Medical Center.

**Facilitators for the cross-cutting strategy sessions were invaluable to a successful and productive summit:** Gerard F. Anderson, The Johns Hopkins University; David Brailer, Health Technology Center; Christine K. Cassel, American Board of Internal Medicine; Russell E. Glasgow, Kaiser Permanente Colorado; Judith Hibbard, University of Oregon; Arnold Milstein, Pacific Business Group on Health; Shoshanna Sofaer, Baruch College; and David M. Stevens, Agency for Healthcare Research and Quality.

**Summit scribes provided timely and vital recording of work produced during the strategy sessions:** Shari M. Erickson, Institute of Medicine; Beverly Lunsford, The Washington Home; Elizabeth McCann, medical student at Columbia College of Physicians and Surgeons; Sydney Morss Dy, the Johns Hopkins Bloomberg School of Public Health; Hsien Seow, The Washington Home; Lynne Page Snyder, Institute of Medicine; and Anne Wilkinson, the RAND Corporation. Special thanks also go to Joanne Lynn of The Washington Home Center for Palliative Care Studies for providing the student volunteers to help with recording.

**Webcasts and transcripts of the summit** were graciously facilitated by the Kaiser Family Foundation. They are freely accessible at <<http://www.kaisernetwork.org/healthcast/iom/06jan04>>.

**Support for this project was generously provided by** The Robert Wood Johnson Foundation. We are also grateful to the Johns Hopkins Bloomberg School of Public Health for its support of the summit's cross-cutting strategy sessions.

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