
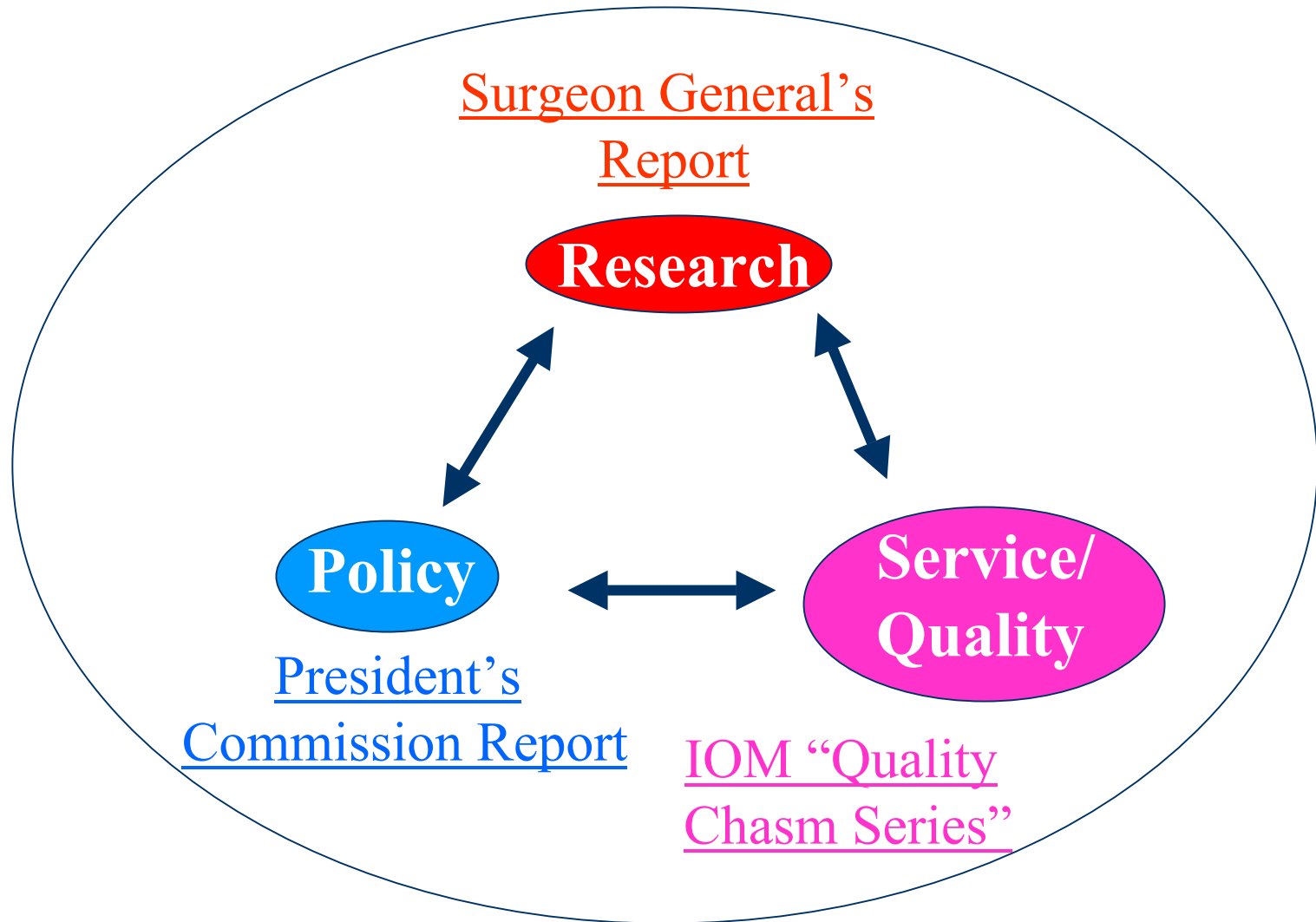


# **Crossing the Quality Chasm; A New Health System for the 21<sup>st</sup> Century**

Allen S. Daniels, Ed.D.  
Professor, Clinical Psychiatry  
CEO, Alliance Behavioral Care  
Executive Director, University  
Psychiatric Services



# A Roadmap for Behavioral Healthcare Reform



# Health Care Policy – The State of the Current Dialogue

- Stakeholder discussions between Purchasers (Feds/States, Employers, Insurers), Providers/Healthcare Systems, and Patients/Families (Consumers-Recipients of care), generally focuses on cost and not quality.
- We currently lack a common vision and roadmap for the design and reform of healthcare systems.
- A constructive dialogue about about health care requires a framework to guide the discussion and chart the course.
- Behavioral Health care is fragmented, difficult to access, and inconsistent in quality

# The Urgent Need to Improve Health Care Quality

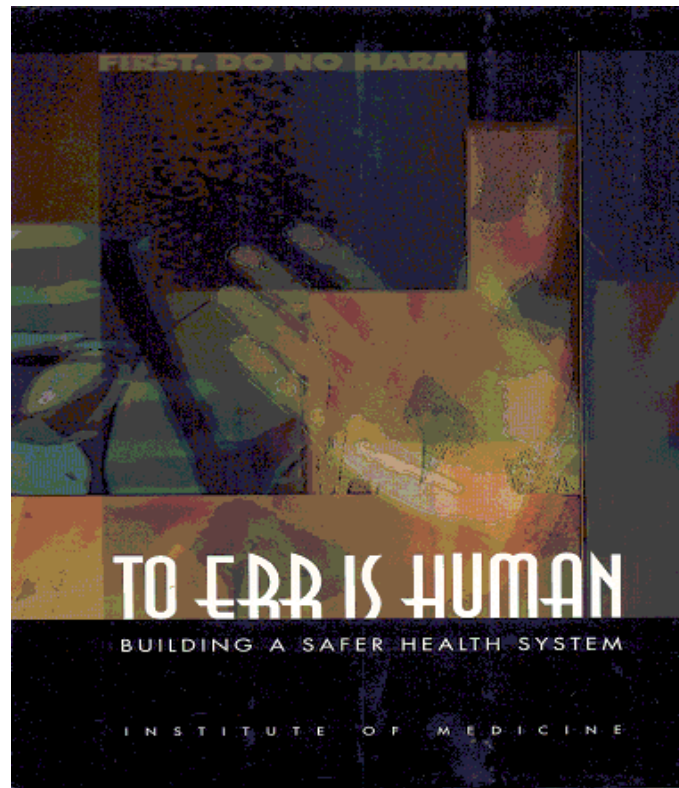
“Our present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a Model T Ford”

Institute of Medicine National Roundtable on Health Care Quality  
*(Chassin & Galvin 1998)*

# IOM and the Quality of Care in America

- **Quality Chasm Series** [www.iom.edu](http://www.iom.edu)
  - **To Err is Human: *Building a Safer Health System*** (2000)
  - **Crossing the Quality Chasm: *A New Health System for the 21<sup>st</sup> Century*** (2001)
  - **Unequal Treatment: *Confronting Racial and Ethnic Disparities in Health Care*** (2002)
  - **Leadership By Example: *Coordinating Government Roles in Improving Health Care Quality*** (2002)
  - **Priority Areas for National Action: *Transforming Health Care Quality*** (2003)

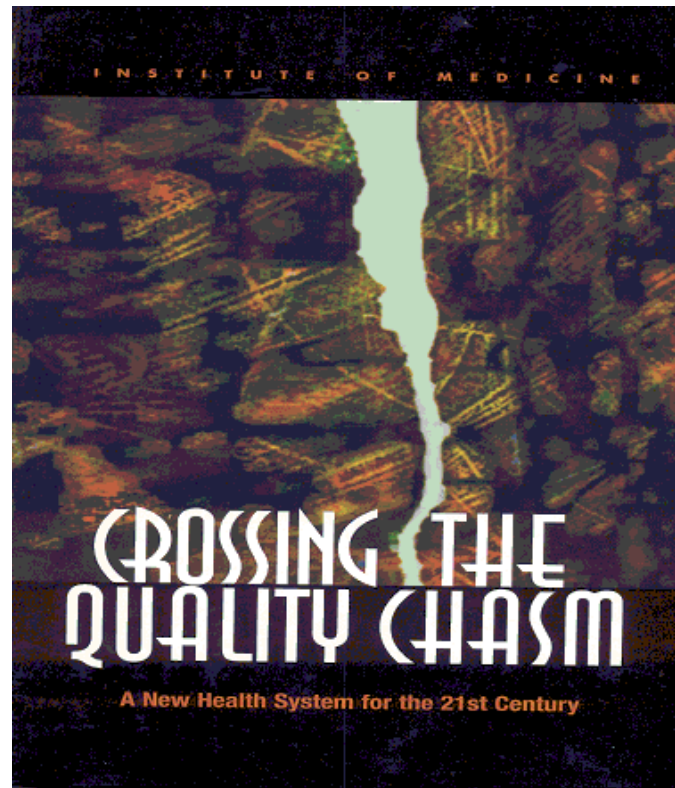
# To Err is Human: *Building a Safer Health System* (Quality Chasm Series, 2000)



# To Err is Human: *Building a Safer Health System* (Quality Chasm Series, 2000)

- “The status quo is not acceptable and cannot be tolerated any longer. Despite cost pressures, liability constraints, resistance to change and seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort.”
- *The Question for Behavioral Healthcare:*  
What constitutes an error and how do we track them?

Crossing the Quality Chasm: *A New Health System for the 21<sup>st</sup> Century* (Quality Chasm Series, 2001)



# Crossing the Quality Chasm: *A New Health System for the 21<sup>st</sup> Century* (Quality Chasm Series, 2001)

- “Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized”
- “trying harder will not work. Changing systems of care will.”
- *The Question for Behavioral Healthcare:*  
Is behavioral healthcare quality different from general healthcare?

# Crossing the Quality Chasm: *A New Health System for the 21<sup>st</sup> Century* (Quality Chasm Series, 2001)

- **Crossing the Quality Chasm**
  - Six Aims for health care
  - Ten Rules
  - Challenges for the redesign of US health systems
  - Critical Environmental Forces

# IOM Six Aims for Improving American Health Care

Health Care should be:

- **Safe** – avoiding injuries from care that is intended to help them
- **Effective** – providing services based upon scientific knowledge and avoiding those not likely to benefit
- **Patient-centered** – care that is respectful and responsive to individual patient preferences, needs, values, and includes patient values in clinical decision making

# IOM Six Aims for Improving American Health Care

Health Care should be:

- **Timely** – reducing waits and sometimes harmful delays for those who receive and give care
- **Efficient** – avoiding waste, in particular - of equipment, supplies, ideas and energy
- **Equitable** – care that does not vary in quality due to personal characteristics (gender, ethnicity, geographic location, or socio-economic status)

# IOM Ten Rules for the redesign of 21<sup>st</sup> Century Health Care Systems

## Currently

1. Care is based on visits.
2. Professional autonomy drives variability.
3. Professionals control care.
4. Information is a record.
5. Decisions are based upon training and experience.

## New Rule

- 1. Care based upon continuous healing relationships.**
- 2. Care customized to patient need and value.**
- 3. Patient is the source of control.**
- 4. Knowledge is shared and information flows freely.**
- 5. Decision making is evidence based.**

# IOM Ten Rules for the redesign of 21<sup>st</sup> Century Health Care Systems - continued

## Currently

6. Do no harm is an individual responsibility.
7. Secrecy is Necessary.
8. The system reacts to needs.
9. Cost reduction is sought.
10. Preference for professional roles over the system.

## New Rule

6. Safety is a system priority.
7. Transparency is Necessary.
8. Needs are anticipated.
9. Waste is continuously decreased.
10. Cooperation among clinicians is a priority.

# Challenges for the Redesign of US Health Systems

1. Redesigning care processes
2. Effective use of information technology
3. Knowledge and skills management
4. Development of effective treatment teams
5. Coordination of care across patient conditions, services, and settings over time
6. Use of performance measures/outcomes for continuous quality improvement and accountability

# Levels of Care/Improving Quality

Berwick 2002

**A. Patients  
and Communities**

**Experience  
of Care**

**6 Aims**

**B. Microsystems  
of Care**

**Process  
of Care**

**10 Rules**

**C. Health Care  
Organizations**

**Facilitators of  
Process**

**Design Concepts: HR,  
Practice standards, IT,  
Teamwork, Coordination  
of care, Performance  
measurement**

**D. Health Care  
Environment**

**External  
Environment of  
Care**

**Financing  
Training/Education  
Public Policy/Legal**

# Road Map For the Implementation of the IOM's Quality Chasm Report

Experience of Patients and Communities

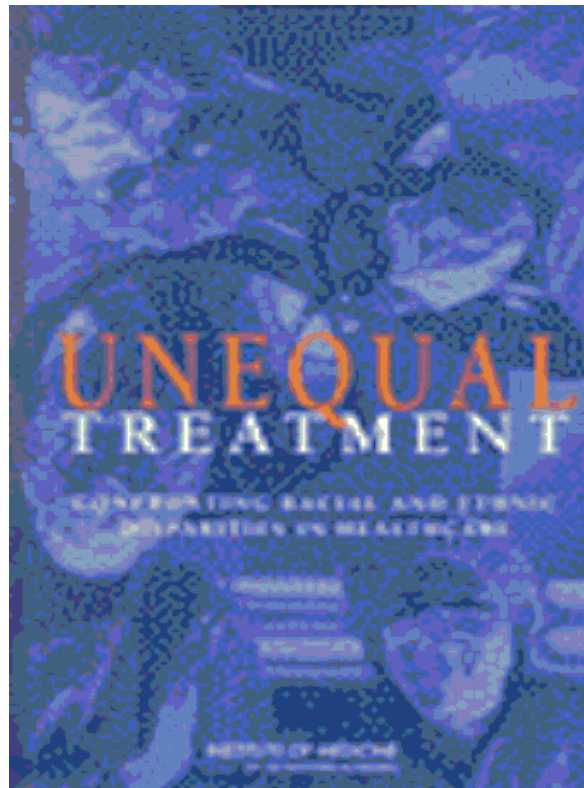
“True North”

Microsystems of Care  
“Where care occurs”

Health care  
Organizations

External Environment of Care  
“Policy/financing/regulation”

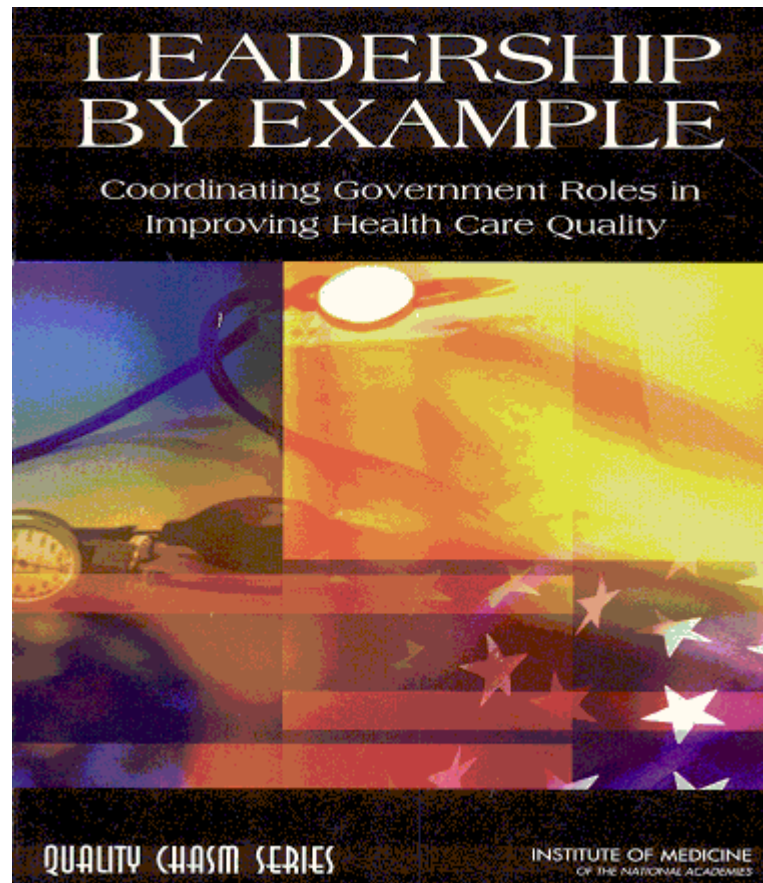
# Unequal Treatment: *Confronting Racial and Ethnic Disparities in Health Care* (2002)



## Unequal Treatment: *Confronting Racial and Ethnic Disparities in Health Care* (2002)

- “Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services. These disparities are associated with socioeconomic differences and tend to diminish significantly, and in a few cases, disappear altogether when socioeconomic factors are controlled.”
- *The Question for Behavioral Healthcare:*  
How are racial and ethnic disparities manifested in behavioral healthcare?

# Leadership By Example: *Coordinating Government Roles in Improving Health Care Quality* (2002)



## Leadership By Example: *Coordinating Government Roles in Improving Health Care Quality* (2002)

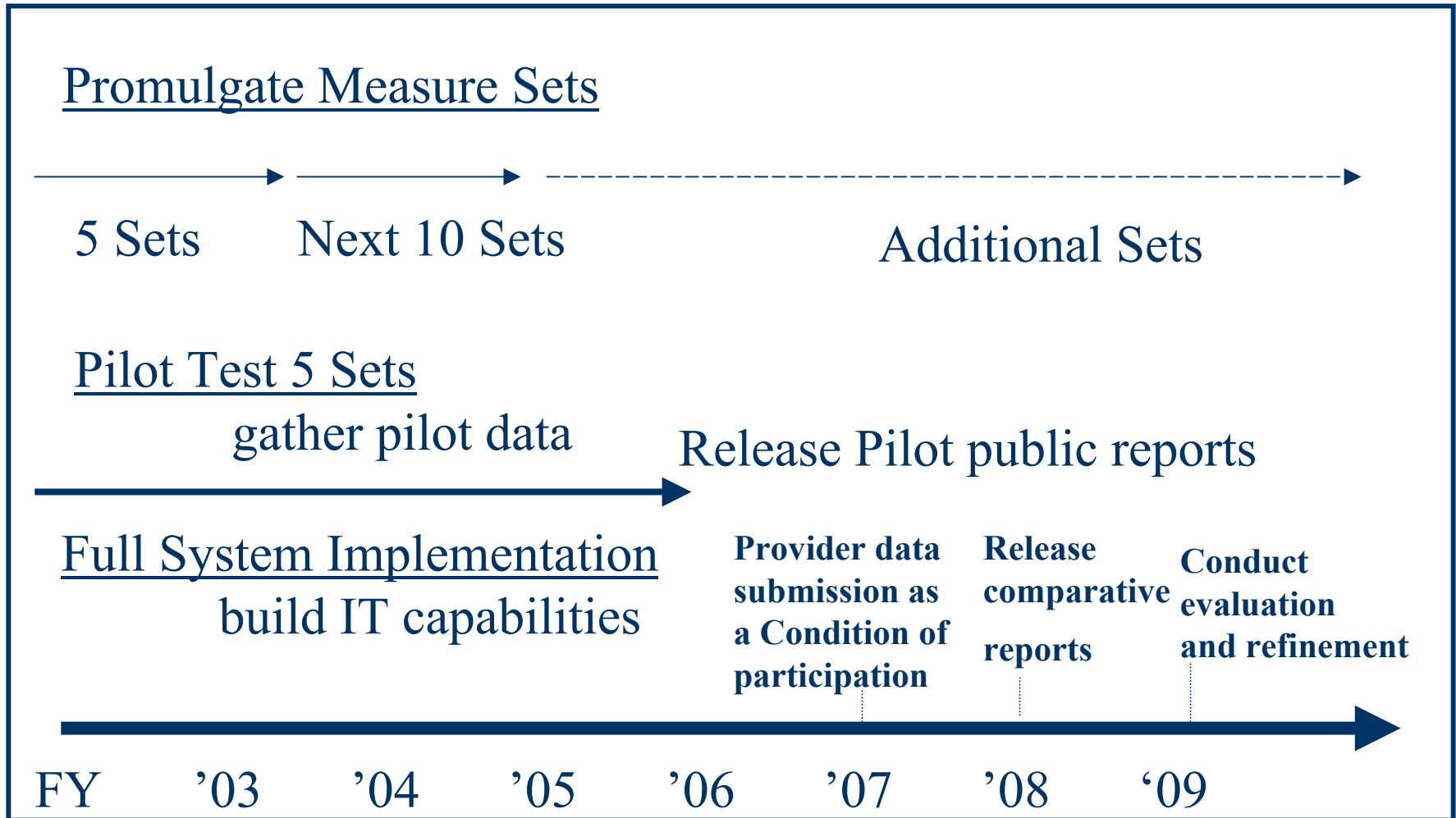
- “A critical first step in addressing the nation’s serious health care safety and quality concerns is the establishment of valid and reliable measurement systems that can be used to assess the degree to which care processes are consistent with the clinical knowledge base and patients are achieving desired outcomes.”
- *The Question for Behavioral Healthcare:*  
Can we develop common systems of performance measurements across the spectrum of behavioral health services?

Leadership By Example: *Coordinating Government Roles in Improving Health Care Quality* (2002)

## Government Healthcare Programs FY'01

<b>Program</b>	<b>Beneficiaries</b>	<b>Expenditures</b>
<b>Medicare</b>	<b>40.0 million aged and disabled</b>	<b>\$242.4 billion</b>
<b>Medicaid</b>	<b>42.3 million low-income, mostly children, pregnant woman, disabled, and aged</b>	<b>\$227.9 billion (joint Federal and State)</b>
<b>SCHIP</b>	<b>4.6 million low-income children</b>	<b>\$4.6 billion (Fed/State)</b>
<b>VHA</b>	<b>4.0 million vets</b>	<b>\$20.9 billion</b>
<b>DOD TRICARE</b>	<b>8.4 million active duty military, families, and retirees</b>	<b>\$14.2 billion</b>
<b>IHS</b>	<b>1.4 million American Indians and Alaska Natives</b>	<b>\$2.6 billion</b>
<b>Total</b>	<b>About 100 million people</b>	<b>\$512.6 billion</b>

# Common Performance Measurement Implementation Time Line



Leadership By Example (2002)



# Common vs. Core Outcomes Measurement

**Ambulatory Counseling Service**

**Facility Based Program**

Core  
Outcomes

Core  
Outcomes

Core  
Outcomes

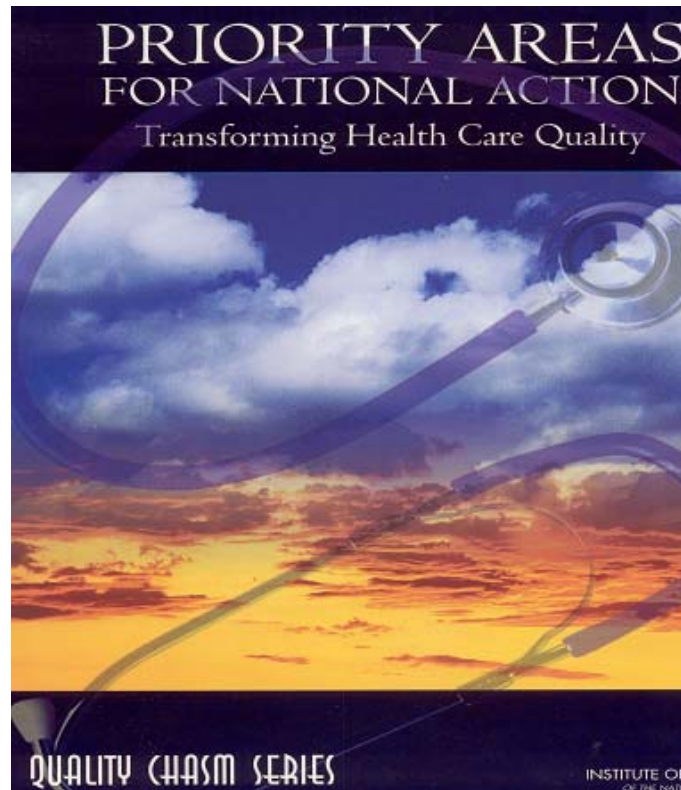
**Community Based Social Services**

**Common Outcome  
Elements**

## Examples of Common Indicators:

1) Access/timeliness, 2) Quality of interaction with providers, 3) Information provided by providers, 4) Perceived overall quality, 5) Perceived cultural sensitivity, 6) Perceived improvement

# Priority Areas for National Action: Transforming Health Care Quality (2003)



# Priority Areas for National Action: Transforming Health Care Quality (2003)

- “The Quality Chasm report recommends the systematic identification of priority areas for quality improvement. The idea behind this strategy was to have various groups at different levels focus on improving care in a limited set of priority areas, with the hope that their collective effort would help move the nation forward toward achieving better quality health care for all Americans.”
- *The Question for Behavioral Healthcare:*  
*Should behavioral health conditions stand alone as categories – or be considered as crosscutting with other diseases?*

# Priority Areas for National Action: Transforming Health Care Quality (2003)

- Criteria for the selection of initial conditions
  - Impact the extent of the burden, disability, mortality and cost imposed by a condition including effects on patients families, communities and societies
  - Improvability the extent of the gap between current practice and evidence-based practice and the likelihood of closing the gap with the use of 6 Aims
  - Inclusiveness the relevance of an area to a broad range of individuals with regard for equity, generalizability, and scope of impact

# Priority Areas for National Action: Transforming Health Care Quality (2003)

1. Care Coordination,
2. Self Management/health literacy,
3. Asthma,
4. Cancer Screening,
5. Children with special health care needs,
6. Diabetes,
7. End of life with advanced organ failure,
8. Frailty associated with old age
9. Hypertension,
10. Immunization,
11. Heart Disease,
12. Major Depression,

Note: Red = Initial set of 5 Priority Conditions

# Priority Areas for National Action: Transforming Health Care Quality (2003)

- 13. Medication Management,
- 14. Nosocomial infections
- 15. Pain control in advanced cancer
- 16. Pregnancy/childbirth – appropriate prenatal and intrapartum care
- 17. Severe and Persistent mental illness –public sector
- 18. Stroke – early intervention and rehabilitation
- 19. Tobacco dependence treatment in adults
- 20. Obesity (emerging area)

Note: Red = Initial set of 5 Priority Conditions

# President's New Freedom Commission – 6 Goals

## Goals:

1. Americans understand that mental health is essential to overall health.
2. Mental health is consumer and family driven.
3. Disparities in mental health services are eliminated
4. Early mental health screening, assessment and referral services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

# IOM Aims and President's Commissions Recommendations; A Roadmap for System Redesign

## IOM Aims

Safe

## President's Commissions Recommendations

- 1.1 Advance and implement campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
- 2.5 Protect and enhance the rights of people with mental illness

# IOM Aims and President's Commissions Recommendations

## IOM Aims

**Patient - Centered**

## President's Commissions Recommendations

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery

# IOM Aims and President's Commissions Recommendations

## IOM Aims Effective

## President's Commissions Recommendations

- 4.2 Improve/expand school mental health programs
- 4.3 Screen for co-occurring mental/substance abuse disorders and link with integrated treatment strategies
- 4.4 Screen for mental disorders in primary health care, across the life span, connect to treatment and supports
- 5.2 Advance evidence-based practices using dissemination and demonstration projects - create a public-private partnership to guide their implementation
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports
- 5.4 Develop the knowledge base in 4 understudied areas: mental health disparities, long-term effects of medications, trauma, and acute health care

# IOM Aims and President's Commissions Recommendations

## IOM Aims

**Efficient**

## President's Commissions Recommendations

2.3 Align relevant Federal Programs to improve access and accountability for mental health services

2.4 Create a comprehensive State mental health plan to coordinate services

6.2 Develop and implement integrated electronic health record and personal health information systems

# IOM Aims and President's Commissions Recommendations

## IOM Aims

**Equitable**

## President's Commissions Recommendations

3.1 Improve access to quality care that is culturally competent

3.2 Improve access to quality care in rural and geographically remote areas

4.1 Promote the mental health of young children

6.1 Use health technology and telehealth to improve access and coordination of mental health care especially for Americans in underserved populations

# IOM Aims and President's Commissions Recommendations

## IOM Aims

### Timely

1.2 Address mental Health with the same urgency as physical health

5.1 Accelerate research to promote recovery and resilience and ultimately to cure and prevent mental illness