

SHAPING THE FUTURE

Newsletter of The IOM

The mission of the Institute of Medicine is to advance and disseminate scientific knowledge to improve human health. The Institute provides objective, timely, authoritative information and advice concerning health and science policy to government, the corporate sector, the professions and the public.

The IOM Quality Initiative: A Progress Report at Year Six

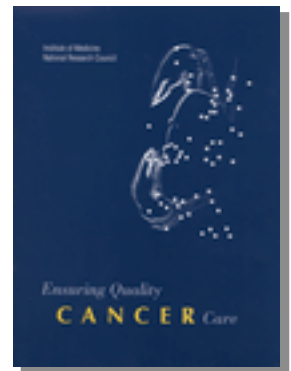
In March 2001, the Institute of Medicine released the report *Crossing the Quality Chasm: A New Health System for the 21st Century*, calling for fundamental change in the health care system. Responding to widespread and persistent, systemic shortcomings in quality, the Committee on the Quality of Health Care in America has challenged the nation to undertake major redesign of both the delivery system and the policy environment that shapes care delivery.



The *Crossing the Quality Chasm* report marks the six-year point of an IOM-wide quality initiative, started under the leadership of Kenneth I. Shine, M.D. The IOM has a long history of addressing quality of care issues. The IOM definition of quality of care, released in 1990, has stood the test of time—addressing both

population and individual level health care needs and encompassing clinician and patient perspectives. But the quality initiative marks the first time that the IOM has initiated a broad-based effort involving multiple Boards and committees, and a series of statements and reports addressing many facets of this complex issue.

The first phase of the quality initiative started with the National Roundtable on Health Care Quality, which issued a statement in 1998 calling attention to “The Urgent Need to Improve Health Care Quality” (Chassin et al., 1998). The Roundtable documented three types of quality problems—overuse, underuse and misuse. An extensive literature review conducted by researchers from The RAND Corporation, released during the same year, provided ample evidence of each type of problem and the serious and pervasive nature of quality concerns (Schuster et al., 1998).



Probing deeply into a specific clinical area, the IOM’s National Cancer Policy Board found that quality problems occur across all types of cancer care and in all aspects of the

Features

Focus Article:

The IOM Quality Initiative: A Progress Report at Year Six	1
Letter from the President	3
Recently Released Reports	5
What’s New at the IOM	6
Announcements	7

Highlight:

Board on Health Care Services	7
-------------------------------------	---

“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Institute of Medicine, 1990

process of care (Institute of Medicine, 1999). In its report, *Ensuring Quality Cancer Care*, the Board concluded that there is a large gap between what care should be and the care that many patients actually experience. For example, problems with breast cancer care include underuse of mammography for early cancer detection, lack of adherence to standards for diagnosis (such as biopsies and pathology studies), inadequate patient counseling regarding treatment options, and underuse of radiation therapy and adjuvant chemotherapy following surgery.

The report of the National Cancer Policy Board did not fall on deaf ears. Shortly after its release, the Department of Health and Human Services formed a Quality of Cancer Care Committee under the direction of the National Cancer Institute to unite the activities of all its agencies toward the improvement of cancer care and undertake a number of new quality initiatives. The National Cancer Institute contracted with the National Quality Forum to begin work on quality indicators for cancer, and the American Society for Clinical Oncology, with funding from the Komen Foundation, began a national study of quality of care delivered by oncologists. Additionally, the National Dialogue on Cancer, an organization of many of the cancer groups and institutions in the nation, highlighted the National Cancer Policy Board report and began looking for ways to implement its major recommendations.

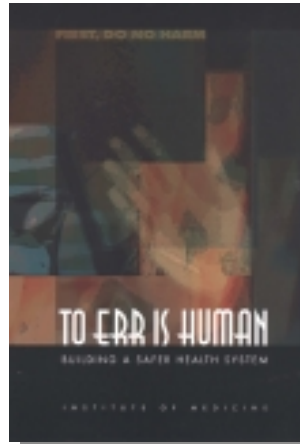
The second phase of the quality initiative began in 1998, with the appointment of the Quality of Health Care in America Committee. Having identified the significant breadth and depth of quality concerns, this new committee was tasked with identifying strategies for achieving a substantial improvement in quality over the coming decade. The committee's first report, *To Err is Human: Building a Safer Health System* (Institute of Medicine, 2000), focused on a specific type of quality problem, namely medical errors. While the final report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, is a call for action to improve the American health care delivery system as a whole, in all its quality dimensions.

In *To Err is Human*, released in 1999, the committee concluded that tens of thousands of Americans die each year from errors in their care, and hundreds of thousands suffer or barely escape from nonfatal injuries that a truly high-quality care system would largely prevent. The report received

extraordinary media coverage—nearly 2-days of near saturation coverage on all national networks and a great deal of local network coverage as well. The American public took notice—51% closely followed the media coverage on medical errors (Kaiser Family Foundation, 1999).

A main conclusion of the report is that no particular group or entity is to blame. Errors are not a “bad apple” problem. And furthermore, finger pointing and placing blame would be a pointless and counterproductive exercise. To reduce medical errors, we need rigorous changes throughout the entire health care system. To paraphrase the report, it may be human to err, but it's also human to create solutions, find better alternatives, and devise new approaches for the challenges ahead.

The response to the committee's first report was swift, positive and ongoing from both public and private sector leaders. The Administration and Congress took action immediately. The President issued an executive memorandum requesting an action plan within 60 days from the Quality Interagency Task Force (QuITC), and subsequently directed the various branches of the federal government to take an inventory of the existing good ideas for reducing medical errors and apply those techniques to the health programs they administer (White House, 1999).



AHRQ has already made progress on the specification of a patient safety research agenda, and efforts are underway:

- to support large demonstrations to test reporting strategies and patient safety interventions;
- to develop and test the use of appropriate technologies to reduce medical errors;
- to support established cross-cutting teams of researchers and health care facilities and organizations in geographically diverse locations, which will determine the causes of medical errors and develop new knowledge to support the work of the demonstrations;
- to develop new multidisciplinary research teams to improve the nation's capacity in patient safety research;
- to develop an understanding of how the environment of care impacts the ability of providers to improve safety; and
- to fund researchers and organizations to develop, demonstrate, and evaluate new approaches to improving provider education in order to reduce errors.

Congress began holding hearings within weeks of the report release and in December 2000 appropriated \$50 million for AHRQ to support research and demonstrations on patient safety (Public Law No: 106-554, 2000).

The Leapfrog Group, an association of private and public sector group purchasers, unveiled a market-based strategy to improve safety and quality, including encouraging the use of computerized physician-order entry, evidence-based hospital referrals, and the use of ICUs staffed by physicians credentialed in critical care medicine (The Leapfrog Group, 2000).

The committee also recommended establishing error reporting systems—a nationwide, mandatory state-based public reporting system for only those errors that result in death or serious injury, and voluntary reporting systems for errors that result in no or minimal harm to patients. This two-pronged approach to reporting is modeled after the approach taken in the airline industry, where accidents resulting in death or serious injury or substantial damage to aircraft are required to be reported to a regulatory entity (i.e., the National Transportation Safety Board) while “near misses” are encouraged to be reported to a non-regulatory entity (i.e., the Aviation Safety Reporting System) to be used for learning purposes only.

During the last year, the National Academy for State Health Policy has convened leaders from both the legislative and executive branches of the states to discuss approaches to improving safety, and has recently completed an initiative to better understand state mandatory reporting requirements for medical errors and adverse events (Flowers and Riley, 2001; Rosenthal et al., 2000, 2001a, 2001b; Rosenthal and Riley, 2001). The AHRQ has also contracted with the National Quality Forum to produce a list of “never events” that might be used by states as the basis of a mandatory reporting system (Quality Interagency Coordination Task Force, 2000).

The committee also recommended federal legislation to protect the confidentiality of information in voluntary reporting systems, where such information pertains to errors that result in minimal or no harm, and is collected and analyzed solely to improve safety and quality. Such legislation would encourage the growth of voluntary, confidential reporting systems so that clinicians and health care organizations can correct problems before serious harm occurs. Congressional hearings have been held on this issue, but as of yet, no action has been taken.

Letter from the President

Dr. Kenneth Shine



Recently Rabbi Jeffrey Wohlburg pointed out that ancient Talmudic scholars identified three unknowables. First was the kind of occupation a child would undertake, second the day of one’s death, and third the day of one’s consolation. The events of September 11, 2001, remind us vividly of the uncertainties of life. Those events also emphasize the importance of living fully the time that we have so that we get optimal meaning from life. The importance of relationships, including family, friends, colleagues, and community are vividly reemphasized for all of us. I am very proud of the way that the staff of the Institute of Medicine have helped each other during and after this crisis. While today’s environment often causes individuals to change jobs more frequently than the Ancients would have imagined, the staff of the Institute of Medicine is fortunate because what we do is so important. Following the aftermath of a great tragedy there is often a tendency to ask ourselves, “Is what I’m doing worth it?” When you consider the millions of people whose lives have been enriched by immunizations, better nutrition, improved quality of patient care, and important developments in technology, just to name a few areas in which we work, we can take solace in knowing that what we do professionally makes an extraordinary difference. Moreover, our efforts to create international relationships and improve global health may, in the long run, be among the most important preventive measures against terrorism that our country possesses.

All of the members, volunteers, and staff who make these efforts possible deserve great credit for these accomplishments. The growth of our programs and the extent to which Congress, the Executive Branch, foundations and others ask us for help is evidence of the meaningfulness of our contributions.

The time of consolation is a very important concept. We can never be completely consoled after the loss of loved ones and friends, yet at some point we find a way to achieve a state of consolation that allows us to remember them fondly without the constant pain associated with loss. Even though we may not

continued on page 8...

Clearly, there is no single solution sufficient to bring about the degree of needed change. Rather, we should think and act systemically, to create an environment where safety will become a top priority for health care organizations and providers. The goal here is not to blame individuals, or to seek retribution. Instead, we want to design new systems that

prevent, detect, and minimize hazards and the likelihood of error. In short, we want to create a new culture of safety in the American health care system. We want a system in which it is hard to make a mistake and easy to do the right thing.

While the findings on medical errors are sobering, perhaps more sobering is the realization that medical errors are but one manifestation of an even larger problem. Or as the committee says in *Crossing the Quality Chasm*, medical errors are the tip of the iceberg. There is ample and growing evidence that much of health care is not strongly science-based (See Appendix A in Institute of Medicine, 2001).

“Medical errors are the tip of the iceberg.”

William C. Richardson, chair IOM Committee
on Quality of Health Care in America

Many people simply do not benefit from what medicine has to offer. As medical science and technology have advanced at an extraordinary pace since the 1960s, the health care delivery system has floundered. We fall short in our ability to translate knowledge into practice, and to apply new technology safely and appropriately. As currently structured, the health care enterprise also does not make the best use of its resources. If the health care system cannot consistently deliver today’s science and technology, it is even less prepared to respond to the extraordinary scientific advances that will emerge during the first half of the 21st century.

Another consequence of advances in medical science, technology and health care delivery is that people are now living longer, and chronic conditions are now the leading cause of illness, disability and death (Hoffman et al., 1996). Although health care is by no means the only factor that effects morbidity and mortality, innovations in medical science and technology have contributed to the increase in life expectancy. As a result of changing mortality patterns, those age 65 and over constitute an increasingly large number and proportion of the U.S. population (National Center for Health Statistics, 1999). In 1994, this age group accounted for approximately 1 in 8 persons, while in 2030, 1 in 5 persons, or 20 percent, is expected to be in this age group.

These demographic changes have very important implications for the organization of the health care delivery system, but we have yet to address these in any significant way. There is a dearth of clinical programs with the

infrastructure to provide the full complement of services needed by people with heart disease, diabetes, asthma or other common chronic conditions. Effective and efficient care of this population necessitates a well-organized program, which includes: an inter-disciplinary team; mechanisms for communication and coordination of services across providers and settings over extended periods of time; education programs and communication mechanisms directed at patients, their families and other informal caregivers; formally organized care processes designed to achieve best practice; and the ability to measure both medical care process and patient outcomes for purposes of quality improvement (Wagner, 2000; Wagner et al., 1996a, 1996b).

In *Crossing the Quality Chasm*, the Quality of Health Care in America Committee has laid out an action plan for redesign of health care including:

- commit to a shared vision of six Aims for Improvement
- adopt ten rules to guide the redesign of health care
- identify and focus redesign efforts on a limited number of “priority conditions”
- create an environment that fosters improvement in quality

The IOM Committee has identified six Aims for Improvement—six dimensions of quality where, we believe, today’s health system functions at far lower levels than it should. Health care should be safe, effective, patient-centered, timely, efficient and equitable.

Aims for Improvement

Safe: avoiding injuries to patients from the care that is intended to help them.

Effective: providing services based on scientific knowledge.

Patient-centered: providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions.

Timely: reducing waits and sometimes harmful delays for both those who receive care and those who give care.

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

To help guide the transition to a better health care system, the Committee identified 10 simple rules for redesign (see Table below). In formulating these rules, the committee was guided by the belief that care must be delivered by systems that are carefully and consciously designed to provide care that is safe, effective, patient-centered, timely, efficient and equitable. Such systems must be designed to serve the needs

contemplated by the 10 simple rules for redesign. The aim of *Pursuing Perfection: Raising the Bar for Health Care Performance*, supported by The Robert Wood Johnson Foundation, is to help a small number of highly committed health care organizations achieve unprecedented performance in an array of core processes at a system level. The program creates the opportunity for great improvement in a few organizations and widespread dissemination to the industry through major grants and technical assistance for health care providers, a learning network to help applicants and other interested providers, and a communication campaign targeting providers and opinion leaders.

The committee recommends that common chronic conditions serve as a starting point for restructuring of health care delivery. Specifically, that a short list of “priority conditions” be promulgated by AHRQ, and that all health care stakeholders focus attention on making substantial progress toward the establishment of state-of-the-art processes for these conditions in the next 5 years. The AHRQ has just requested guidance from the IOM on the selection of an initial set of priority conditions, and this IOM report is expected to be released in September 2002.

To enable the profound changes in health care recommended in the report, the environment of care must also change. Specifically, changes need to occur in the information

Simple Rules for the 21st-Century Health Care System

Current Approach	New Rule
Care is based primarily on visits.	Care is based on continuous healing relationships.
Professional autonomy drives variability.	Care is customized according to patient needs and values.
Professionals control care.	The patient is the source of control.
Information is a record.	Knowledge is shared and information flows freely.
Decision making is based on training and experience.	Decision making is evidence-based.
Do no harm is an individual responsibility.	Safety is a system property.
Secrecy is necessary.	Transparency is necessary.
The system reacts to needs.	Needs are anticipated.
Cost reduction is sought.	Waste is continuously decreased.
Preference is given to professional roles over the system.	Cooperation among clinicians is a priority.

Source: Institute of Medicine, 2001.

of patients, and to ensure that they are fully informed, retain control and participate in care delivery whenever possible, and receive care that is respectful of their values and preferences. Such systems must facilitate the application of science to practice, and provide clinicians with the tools and supports necessary to deliver evidence-based care consistently and safely.

Under the leadership of Donald M. Berwick, President and CEO of the Institute for Healthcare Improvement and member of the IOM committee, a new national initiative is now underway to stimulate the kind of cultural and systems changes

Recently Released IOM Reports

- **Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence (IOM/CBSSE)**
- **Stem Cells and the Future of Regenerative Medicine (DELS/IOM)**
- **Unintended Consequences of Health Policy Programs and Policies: Workshop Summary**
- **The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in Health Professions. Summary of the Symposium on Diversity in Health Professions in Honor of Herbert W. Nickens, M.D.**
- **IOM and Agency for Healthcare Research and Quality Workshop on Medical Evidence in the Courts. Featured in the Journal of Health Politics, Policy And Law**
- **Gulf War Veterans: Treating Symptoms and Syndromes**
- **Interpreting the Volume-Outcome Relationship in the Context of Cancer Care. (Report and Workshop Summary)**

technology infrastructure, payment policies and preparation of the health care workforce.

The IOM Committee concluded that information technology must play a central role in the redesign of the health care system if a substantial improvement in quality and safety is to be achieved over the coming decade. The Internet has enormous potential to transform health care as it has nearly every other facet of society.

But the challenges of applying information technology to health care should not be underestimated. Health care is undoubtedly one of the most, if not *the* most, complex sector of the economy. Sizable capital investments and multiyear commitments to building systems will be required. Widespread adoption of many information technology applications will require behavioral adaptations on the part of large numbers of patients, clinicians, and organizations. And last but not least, there is a critical need for national standards including: standards for the coding and classification of data, clinical standards for quality measurement, standards for protecting the confidentiality of personally-identifiable patient data, and standards for determining the integrity of information on Web sites. In the absence of a national commitment and financial support to build a national health information infrastructure, progress on quality and safety improvement will be painfully slow.

The IOM, working in collaboration with many other groups, intends to address some of these important information technology issues over the coming few years. A new IOM project is just getting underway, with support from AHRQ, to provide guidance on the development of standards for the collection, coding and classification of patient safety data. In Fall 2001, the IOM co-sponsored with the Kaiser Permanente Institute for Health Policy, a meeting of leading experts to learn more about the potential benefits and costs of clinical

information systems; and in early 2002 the IOM is co-sponsoring a summit on information technology with the National Quality Forum and others.

Changes will also be needed in the ways that we pay for health services. Current payment policies do not adequately encourage or support the provision of quality health care. Although payment is not the only factor that influences provider and patient behavior, it is a very important one. Too little attention has been paid to the careful analysis and

alignment of payment incentives with quality improvement. The current health care environment is replete with examples of payment policies that work against the efforts of clinicians, health care administrators and others to improve quality. For example, a safety improvement initiative that reduces adverse drug events may also reduce payments for physician visits or shift hospital patients into DRG categories that are less complicated and generate less revenue. Under current visit-

based payment systems, clinicians also have little incentive to communicate with patients through e-mail.

There will also need to be changes in health professional norms and ethics and in education and training programs. Quality health care cannot be delivered through a cottage industry any longer. Well-designed care processes based on sound clinical and engineering principles, and that make the best use of information technology and human resources are essential. Health care today is more and more an interaction between the system and a person who needs help from that system. To be sure, the physician plays a critical role, but his/her effectiveness is increasingly determined by the characteristics of the system they practice within.

The traditional emphasis in clinical education, particularly medical education, has been on teaching a "core of knowledge," much of it focusing on the basic mechanisms of disease and patho-physiologic principles. Given the expansiveness and dynamic nature of the science-base in health

WHAT'S NEW at the IOM?

Newly initiated studies include:

- Subcommittee on Community Effects of Uninsured Populations (Committee on Consequences of Uninsurance)
- Emerging Microbial Threats to Health in the 21st Century
- Review of USDA E. Coli 0157:H7 Farm-to-Table Process
- Roles of Academic Health Centers in the 21st Century
- Improving Research Information and Data on Firearms (CBSSE/IOM)

care, this approach should be expanded to teach how to manage knowledge and use effective tools that can support clinical decision-making. Similarly, as more care is provided in teams, more opportunities for interdisciplinary training should take place.

To address the need for change in the education and training of health professionals, the IOM in collaboration with the Council on Graduate Medical Education, the National Advisory Council on Nurse Education and Practice and others, will be sponsoring a national summit in June 2002 to engage leadership in the development of an action agenda.

In summary, the changes needed to realize a substantial improvement in quality involve all aspects of the health care system, and strong leadership and a spirit of collaboration will be critical to their success. There are serious shortcomings in the American health care system, but they are not intractable and there are already early signs of progress being made.

William C. Richardson
Chair, IOM Quality of Care in America Committee
President and CEO, W.K. Kellogg Foundation

Janet M. Corrigan
Director, IOM Board on Health Care Services

The following Board on Health Care Services studies are ongoing:

- The Evaluation of Selected Federal Health Care Quality Activities
- Review of the Social Security Administration's Disability Decision Process
- The Consequences of Uninsurance
- The Role of Academic Health Centers in the 21st Century
- Immunization Finance Workshops for the IOM Report, Calling the Shots

For information about these studies, please call 202-334-2165 or e-mail Administrative Assistant Tony Burton at tburton@nas.edu.

Announcements

The IOM announces the 2001-2002 Robert Wood Johnson Health Policy Fellows. They will serve in congressional or executive offices with responsibilities for health legislation or programs:

Doug Campos-Outcalt, M.D., M.P.A., medical director, Maricopa County Department of Public Health, Phoenix, AZ

Howard P. Forman, M.D., M.B.A., associate professor of Radiology and Management and vice chair, Department of Diagnostic Radiology, Yale University School of Medicine, New Haven, CT

Suzanne Bennett Johnson, Ph.D., professor and director, Center for Pediatric Psychology and Family Studies, University of Florida Health Science Center, Gainesville, FL

Louis A. Kazal, Jr., M.D., chief medical officer, Navajo Health Foundation, Sage Memorial Hospital, Ganado, AZ

Andrew G. Kumpuris, M.D., private physician, St Vincent's Hospital, Little Rock, AR

Scott S. Young, M.D., executive vice president, Utah Healthcare Institute, Midvale, UT

Additional information on the fellowship program can be found at www.iom.edu/rwj.

References

Public Law No: 106-554. 2000. Online. Available at <http://thomas.loc.gov/cgi-bin/query/z?c106:H.R.4577.ENR>: [accessed June 19, 2001].

Chassin, Mark R., Robert W. Galvin, and the National Roundtable on Health Care Quality. The Urgent Need to Improve Health Care Quality. *JAMA* 280(11):1000-5, 1998.

Flowers, Lynda and Trish Riley. *State-based Mandatory Reporting of Medical Errors: An Analysis of the Legal and Policy Issues*. Portland, ME: National Academy for State Health Policy, 2001.

Hoffman, Catherine, Dorothy P. Rice, and Hai-Yen Sung. Persons With Chronic Conditions. Their Prevalence and Costs. *JAMA* 276(18): 1473-9, 1996.

Institute of Medicine *Medicare: A Strategy for Quality Assurance. Volume I*. K. N. Lohr, ed. Washington, DC: National Academy Press, 1990.

Ensuring Quality Cancer Care. Maria Hewitt and Joseph V. Simone, eds. Washington, D.C.: National Academy Press, 1999.

To Err Is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C: National Academy Press, 2000.

References continued...

Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press, 2001.

Kaiser Family Foundation. 1999. "Health News Index - November/December 1999." Online. Available at <http://www.kff.org/content/2000/1565/> [accessed June 18, 2001]. National Center for Health Statistics

Health, United States, 1999. With Health and Aging Chartbook. Hyattsville, MD: U.S. Government Printing Office, 1999.

Quality Interagency Coordination Task Force. 2000. "Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impacts." Online. Available at <http://www.quic.gov/report/index.htm> [accessed June 18, 2001].

Rosenthal, Jill, Maureen Booth, and Anne Barry. *Cost Implications of State Medical Error Reporting Programs: A Briefing Paper.* Portland, ME: National Academy for State Health Policy, 2001a.

Rosenthal, Jill, Maureen Booth, Lynda Flowers, and Trish Riley. *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives.* Portland, ME: National Academy for State Health Policy, 2001b.

Rosenthal, Jill and Trish Riley. *Patient Safety and Medical Errors: A Road Map for State Action.* Portland, ME: National Academy for State Health Policy, 2001.

Rosenthal, Jill, Trish Riley, and Maureen Booth. *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey.* Portland, ME: National Academy for State Health Policy, 2000.

Schuster, Mark A., Elizabeth A. McGlynn, and Robert H Brook. How Good is the Quality of Health Care in the United States? *The Milbank Quarterly* 76(4):517-63, 1998.

The Leapfrog Group. 2000. "The Business Roundtable Launches Effort to Help Reduce Medical Errors Through Purchasing Power Clout." Online. Available at <http://www.leapfroggroup.org/PressEvent/PressRelease.pdf> [accessed June 18, 2001].

Wagner, Edward H. The Role of Patient Care Teams in Chronic Disease Management. *BMJ* 320:569-72, 2000.

Wagner, Edward H., Brian T. Austin, and Michael Von Korff. Improving Outcomes in Chronic Illness. *Managed Care Quarterly* 42(2):12-25, 1996a.

Organizing Care for Patients with Chronic Illness.—*Milbank Quarterly* 74(4):511-42, 1996b.

White House. 1999. "Remarks by the President on Health Care. The Rose Garden. December 7, 1999." Online. Available at <http://www.ahrq.gov/wh120799.htm> [accessed June 19, 2001].

Continued from page 3...

personally know anyone who was lost in the terrorist attacks, we identify with those who died and feel real pain. Consolation is achieved at different times under different conditions and in different ways by each of us. Fortunately for the overwhelming majority of people, consolation does ultimately come.

While the Institute of Medicine will participate in a number of projects dealing with terrorism, performing the rest of our work effectively is as important as it was before September 11, 2001. We cannot and will not allow terrorism to divert our attention from the important issues in health that must be addressed.

This Newsletter focuses on our work in Quality of Health and Healthcare. It was a self-initiated effort that was almost entirely funded with internal IOM/NRC monies. An important grant from the Commonwealth Foundation helped us initially. This work has literally changed the landscape for Quality in America. Health professionals, academic societies, hospitals, insurers, corporations, consumers and the general public, among others, have to be stirred to action. We must sustain and extend these efforts. Moreover, the concept of an over-arching theme that produced this initiative is also the basis of a six report project funded by the Robert Wood Johnson Foundation tasked to analyze the issues around Americans who lack health insurance. To all of the volunteers, members and staff who participated in this effort, the IOM and the country are grateful. Bill Richardson, Chair of our Committee and Janet Corrigan, the Staff Director, deserve particular commendations. Future newsletters will highlight other areas where the IOM has made a difference.

Kenneth I. Shine, M.D.

Please contact us ...

Institute of Medicine
Office of Reports and
Communications
2101 Constitution Avenue, N.W.
Washington, DC 20418

(202) 334-2352

For More Information

www.iom.edu

The IOM website provides organizational information as well as information about current and upcoming IOM projects, activities, and reports.