consumers believe they receive good or excellent care.

Commenting on this schism between the quality experts and consumers, Robert Blendon, PhD, of Harvard’s School of Public Health said, “What you have is a movement among the elite — the professors and scientists who have discovered that there are very real problems. ... But it’s going to be a while before average citizens believe that. They have a lot of trust in their physicians.”

Bridging the Healthcare Gap

In 2001, the IOM released its third and final report, Crossing the Quality Chasm: The IOM Health Care Quality Initiative. In 1998, IOM formed the Committee on Quality of Health Care in America, charged with developing a strategy that would result in a much-improved healthcare system over the next 10 years. The committee conducted an intensive review of the literature, including data from the Rand Study.

In its final report, the committee noted that, despite rapid technological advances over the past 25 years of the 20th century, it was a period of “mergers, acquisitions and affiliation” — restructuring doing very little to improve the delivery of healthcare services.

The committee’s conclusions related directly to the report’s title: “Quality problems are everywhere, affecting many patients. Between the healthcare we have and the care we could have lies not just a gap, but a chasm.” To cross this chasm, the committee emphasized that new systems of care had to be implemented to improve quality.

To provide quality care for all Americans, six areas of improvement were proposed in the report. These are:

- safety — avoiding injuries to patients from care they receive;
- effective — providing services based on scientific knowledge or evidence-based practice for those in need and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively);
- patient-centered — providing care respectful of and responsive to individual patient preferences, needs and values, and insuring that patient values guide clinical decisions;
- timely — reducing waits and harmful delays for those who receive and give care;
- efficient — avoiding waste of equipment, supplies, ideas and energy; and
- equitable — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

While the 323-page report is written with much detail and complexity, its goals and content have been heralded by quality experts. Its recommendations have become a primary source for driving change in healthcare today.

Blueprint for Nursing

When panelists at the Penn conference in May 2002 discussed how most consumers receive information about physicians and hospitals, one member said, “Most ask a nurse.” Other panel members nodded in agreement.

Nurses need a working knowledge of quality-related issues. When nurses understand quality indicators and quality management, they are better prepared to assist consumers in making informed decisions about their healthcare.

This article provides an overview of the history of quality theory and measurement, including the seminal documents providing information and data related to healthcare quality in America. Information also is provided about government agencies and business groups leading the quality initiative. Finally, nursing’s leadership role in improving quality healthcare will be discussed.

This article distills information available on this vast subject, and presents only major points and outcomes. It is hoped nurses will be challenged to learn more about the initiatives discussed, become members of quality control committees at their facilities and serve as advocates to ensure quality improvement remains an ongoing goal in healthcare.

Quality Defined

Over the years, experts have defined quality in many different ways. AHRO defines quality as doing the right thing, at the right time, in the right way, for the right person — and having the best possible results. In medicine, Ernest A. Codman, MD, a surgeon at Massachusetts General Hospital, Boston, is generally credited with being the first healthcare professional to study patient outcomes. In 1910, he began keeping detailed card files of his patients and recommended that physicians examine patients 1 year after treatment to evaluate its effectiveness. His work was the impetus for the Hospital Standardization Program adopted by the American College of Surgeons (ACS) in 1918.

When the ACS began inspecting hospitals, the minimum standards were contained on one page. However, out of 692 hospitals, only 89 met the requirements. From these early programs to measure quality, the ACS saw the need to improve the process and establish additional standards.

JCAHO Beginnings

In 1951, the Joint Commission on Accreditation of Hospitals (JCAH) was formed as a separate entity of ACS and officially took over the hospital standardization program. In 1953, JCAH published the first Standards for Hospital Accreditation. Until 1970, physician teams surveyed hospitals. That year, RNs and hospital administrators joined the survey teams. In 1987, the organization’s name was changed to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), reflecting the expanded scope of accreditation to facilities beyond hospitals, such as long-term care units and hospice programs.

Since its inception, the organization’s mission has been “to continually improve the safety and quality of care provided to the public through accreditation and related services that support performance improvement in healthcare organizations.”

In the United States, about five out of six hospitals voluntarily request accreditation through JCAHO, with 16,000 site visits taking place annually.

Advantages for healthcare organizations receiving JCAHO accreditation include:

- eligibility to receive Medicare funds;
- ongoing, systematic assessment of practices; and
- demonstration to healthcare and gov-