

From worst to first

Putting quality improvement into practice

By Caron Lee, M.S., and John Johnson

Are you sure that CPMG is number 13? Tom Rolewicz, M.D., chief medical officer at Columbia Park Medical Group (CPMG), repeated the question, more to himself than to anyone else leaving the meeting.

It was November 2003, and Minnesota Community Measurement (MNCM) had just released its annual quality report with coded data representing the participating medical groups and clinics. Rolewicz couldn't believe that CPMG wasn't ranked near the bottom of the pack of numbers that coded for medical groups, as he had expected for many of the measures listed in the report. Rather, he spotted the group's name at number 13, toward the middle. CPMG wasn't last anymore!

When the MNCM quality report was released in November 2004, CPMG's rankings had improved; it was now a top performer in childhood immunizations and had dramatically raised its ratings in diabetes care.

Fast-forward to November 21, 2005. Rolewicz is at the governor's office to receive an award for CPMG's performance as one of the top four clinics (of 54) on MNCM's measure for optimal diabetes care.

What's this? In just a few years, CPMG had become a top performer in providing diabetes care, and was actively working to integrate quality improvement into its organizational culture. How did this happen?

Leadership and support

After joining CPMG in February 2003, Rolewicz worked quickly to make quality the heart of the medical group. As the CMO, Rolewicz had assumed a role that conferred a certain level of formal leadership as head of the group's physicians and an ex-officio board member.

From the start, Rolewicz was able to mobilize support for quality improvement efforts at the administrative and physician levels of the organization. He worked toward institutionalizing evidence-based guidelines and standard processes, for example, by pushing for all CPMG physicians to use diabetes flow sheets.

Knowing that younger physicians tend to more readily embrace the use of guidelines and the standardization of processes to improve quality, Rolewicz supported leadership efforts by newer physicians, who made up about 60 percent of CPMG medical staff. The message was clear: continuing with the old model of physician autonomy without bounds was no longer acceptable. Three physicians eventually left the group because they had difficulty adapting to these changes in the practice model.

Informal leadership efforts

Kathy Keller, the former senior director of medical services, became a pivotal informal leader within the organization. In over 30 years at the medical group, Keller developed trust and credibility with physicians, staff members, and administration. She also developed a deep understanding of organizational dynamics and leadership as well as building relationships and skillfully exercising influence. Both Rolewicz and Keller were committed to quality and understood the need for system-level change to provide better care to patients.

Shortly after Rolewicz joined CPMG, the International Diabetes Center (IDC) accepted the medical group as a diabetes study participant. To maximize this opportunity, Rolewicz and Keller convinced senior leadership to mandate and to compensate physicians for attending an all-day Saturday retreat about the IDC study. All doctors were required to participate in the study, including using the IDC's recommended guidelines and tools.

The results speak for themselves. Between 2002 and 2004, CPMG's rate for optimal diabetes care rose from 7 percent to 28 percent according to Minnesota Community Measurement's annual quality reports. Since then, CPMG has followed suit with similar

approaches to improve other areas of care, including immunizations, depression care, and patient safety.

A multidisciplinary approach

During the spring of 2004, several individuals who were passionate about quality improvement formed an informal quality improvement committee for CPMG. Their approach to quality improvement included the following key elements:

- Leadership influence on administration and staff;
- Financial incentive for quality improvement; and
- Internal education of the staff on quality improvement efforts and Institute for Clinical Systems Improvement (ICSI) assignments.

The importance of this informal leadership team cannot be exaggerated. Its members came from vastly different disciplines and worked together as peers, functioned as a team, and brought depth and breadth to quality improvement leadership at CPMG.

Since 2004, CPMG has had formalized multidisciplinary committees and structures that ensure quality improvement integrated into the medical group's practice. It formed a quality management group at the administrative level that works with the facility operations group at each of CPMG's five clinics. At each clinic site, it created "assistant facility director" positions filled by physicians who report to Rolewicz and serve as liaisons with ICSI.

Support from ICSI

ICSI is a Minnesota-based, independent nonprofit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals, and health plans. Its work includes producing evidence-based guidelines, protocols, and order sets and facilitating "action group" collaboratives. The action groups bring together medical groups and hospitals to share strategies and best practices as a means of accelerating their quality improvement work.

In October 2004, the CPMG board of directors agreed to compensate physicians for their time spent outside the clinic on quality improvement activities, such as participating on

the ICSI work groups that produce evidence-based guidelines. To send the message that CPMG was serious about its commitment to quality, the board designated \$10,000 to compensate physicians for time spent on quality improvement.

According to Rolewicz, “Participating in ICSI’s Cultivating Quality Series (CQS) and joining action groups, such as on diabetes care, imposed discipline on CPMG to establish quality improvement committees, regular meeting times for these committees, and internal structures to ensure frequent and reliable communication.”

During 2005-2006, CPMG participated in ICSI’s action group Leading a Culture of Quality (LCQ). Involvement in the collaborative of ten medical groups supported CPMG’s examination of its organizational culture and values. Through participation in the LCQ action group, CPMG found valuable tools and resources to improve communication with staff, such as the idea of creating a “compact” with its physicians, and a staff survey to gauge the group’s culture and assess changes over the year.

Improved communication with physicians has been one of the most critical successes resulting from participation in the LCQ action group. “The development of guidelines used to be handled behind closed doors because it was assumed that there was no way to bring physicians together. Now we handle things in the open and assume that there is a way to bring physicians together,” says Rolewicz.

Responding to the market

Pressures from the external environment—namely, changes in the health care market, payer demands, and increasing focus on patient satisfaction and customer service—have also been major drivers for CPMG’s support and integration of quality improvement. The rise of pay-for-performance programs and pressure exerted by health plans have significantly strengthened the case for quality.

In 2002, CPMG met quality goals for four programs that paid a total of \$91,200. It did not meet the requirements for three other programs that would have paid \$96,800. By October 2004, CPMG estimated a quality “upside” for 2004 and 2005 worth \$1.58

million from meeting health plan quality or performance goals linked to financial incentives.

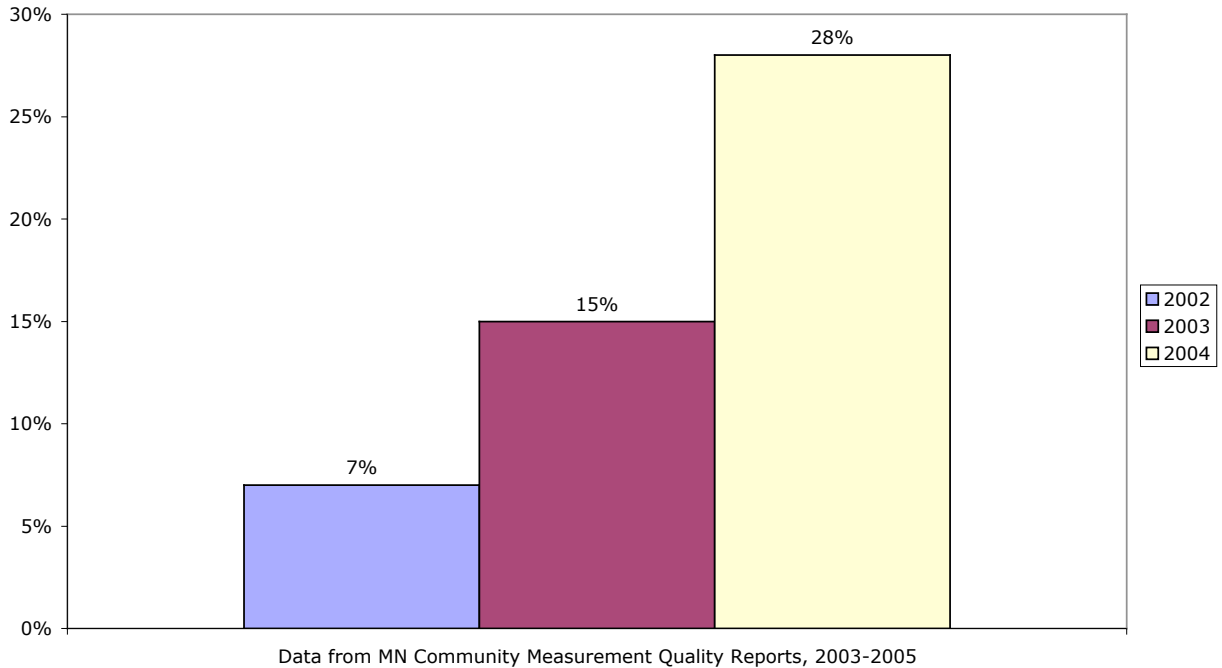
Increased exposure through public reporting, such as MNMCM, has also provided strong motivation to pursue quality improvement. CPMG is aware of the effect on the public perception of the organization, as well as how to internally leverage public reporting to motivate its physicians to change. In spring of 2003, HealthPartners publicly released customer service ratings of medical groups. CPMG rated last. The poor performance rating was communicated throughout the organization and used as an enabler of change.

Results

During the past few years, CPMG has particularly targeted its quality improvement efforts on diabetes care and childhood and adolescent immunizations.

Based on the MN Community Measurement quality reports, CPMG's rates for the optimal diabetes care measure rose each year between 2002 and 2004, totaling an increase of 21 percent over three years. In 2004, the weighted rate was 15.5 percent for all groups reported by MN Community Measurement; CPMG's rate for optimal diabetes care was 28 percent (see Table 1).

Table 1. Columbia Park Medical Group comparative data on optimal diabetes care: HbA1c<=8, BP<130/80, LDL<130, daily aspirin use, tobacco free (2002-2004)



The medical group also demonstrated improvements on several other measures for patients with diabetes. Between 2003 and 2004, the percentage of patients with HbA1c < 8.0 rose from 66 percent to 81 percent; the percentage of diabetes patients with blood pressure < 130/85 increased from 49 percent to 61 percent; and the percentage of patients (over 40) who take aspirin daily rose from 56 percent to 89 percent.

Childhood and adolescent immunization status (including chickenpox) at CPMG also rose significantly (see Tables 2 and 3). Immunization status was defined as percentages of child or adolescent patients with all required immunizations. Between 2002 and 2004, CPMG's childhood immunization status rose from 68 percent to 81 percent; the 2004 weighted rate for all participating medical groups for childhood immunization status was 67.8 percent. CPMG's adolescent immunization status increased from 27 percent to 60 percent between 2003 and 2004. (CPMG did not participate in this measure in 2002.) The weighted rate for all medical groups on this measure was 38.9 percent in 2004.

Table 2. Columbia Park Medical Group comparative data on childhood immunization status (including chickenpox), 2002-2004

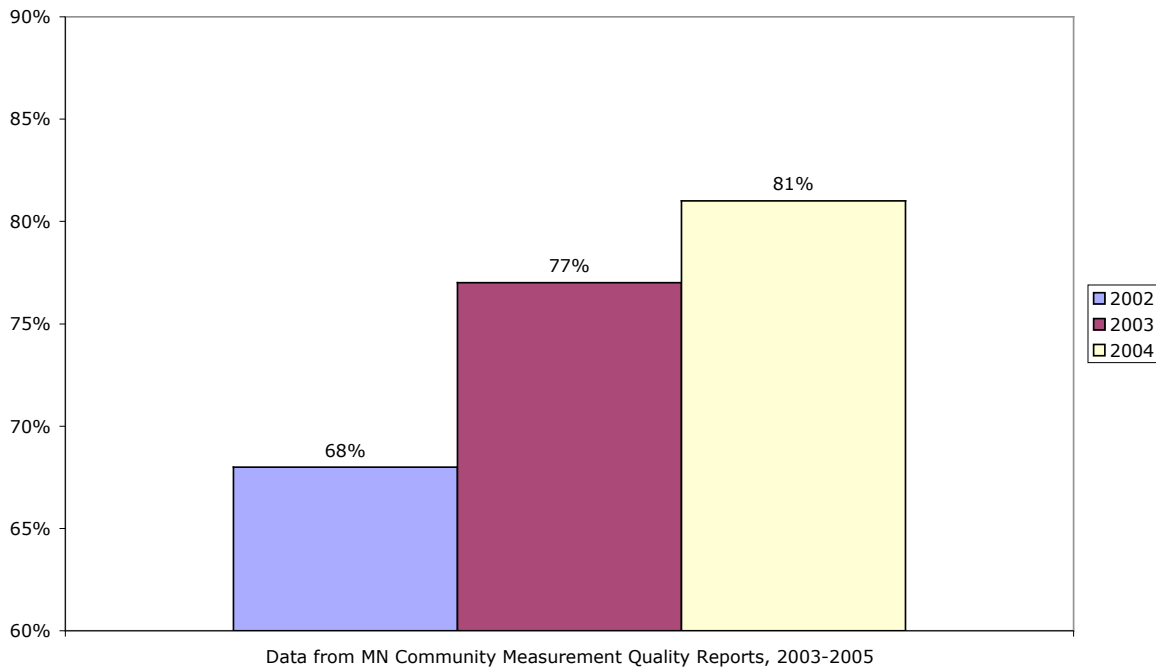
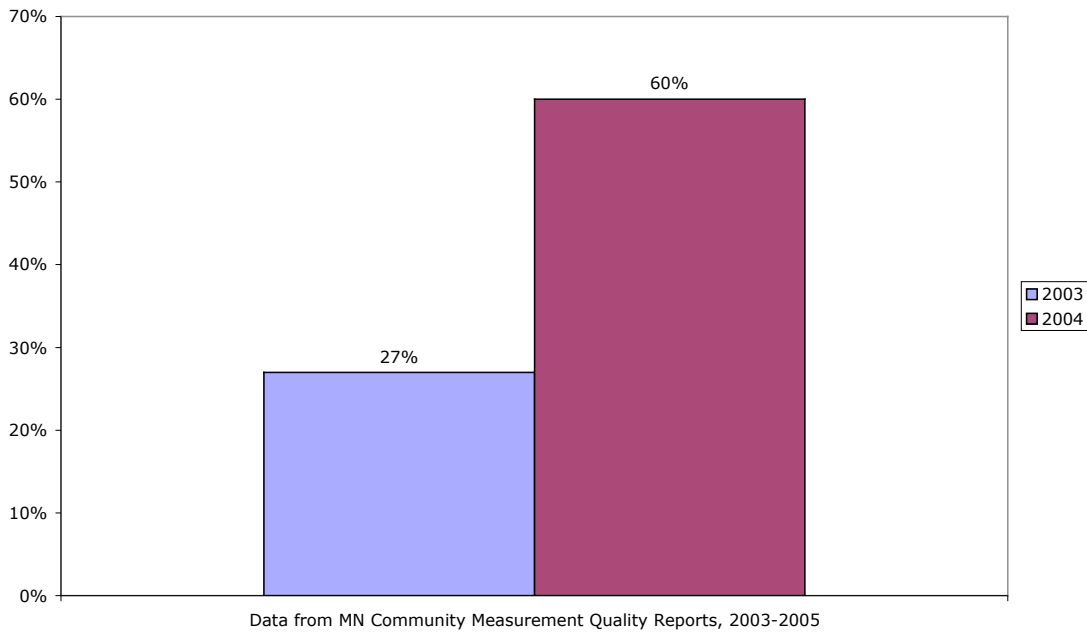


Table 3. Columbia Park medica Group comparative data on adolescent immunization status (including Chickenpox), 2003-2004



On the horizon

CPMG has come a long way in just three years, rising from near the bottom of Minnesota Community Measurement's rankings for diabetes care and immunizations to become one of the state's top-performing medical groups. It has reorganized itself internally to orient its strategic plan and the overall organization toward quality improvement and providing the best care possible to its patients. Of the group's organizational transformation, Keller said, "CPMG used to approach quality as 'hat in hand,' something that we almost had to beg people to do. Today, quality is a major issue that is integral to the medical group's mission."

Nevertheless, there is much work to be done. The group's next areas of focus include team building internally, further developing a shared organizational vision, reducing clinical "silos," and improving patient satisfaction. To support this work, CPMG will continue to participate in ICSI's next LCQ action group.

Rolewicz points to the 180-degree shift in physician perception of quality improvement as one of CPMG's greatest successes. "Some of the long-term physicians have changed their attitudes to the point that they are some of the staunchest champions for quality."

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Table 4: CPMG's Performance on Minnesota Community Measurement Measures, 2002-2004

	2003 Quality Report (Based on 2002 Measurement Year) - 54 participating medical groups	2003 Mean	2004 Quality Report (Based on 2003 Measurement Year) - 51 participating medical groups	2004 Mean	2005 Quality Report (Based on 2004 Measurement Year) - 54 participating medical groups	2005 Mean
Appropriate Medication for People with Asthma (Age 5-56)	75%	70.9%	76%	73.8%	78%	75.9%
Appropriate Medication for People with Asthma (Age 5-17)					79%	76.5%
Appropriate Medication for People with Asthma (Age 18-56)					78%	75.6%
Remaining on Antidepressant Medication for 180 days	43%	49.4%	42%	50.6%	47%	49.3%
Follow-up Visits for Depression	12%	16.1%		66.0%		65.8%
Childhood Immunization Status including Chickenpox	68%	62.7%	77%	63.6%	81%	67.8%
Adolescent Immunization Status including Chickenpox	NA	26.7%	27%	35.0%	60%	38.9%
Well Child Care - 6 visits or more in the first 15 mo of life	58%	44.5%	60%	53.1%	61%	58.8%
Well Child Care Visits in the 3rd, 4th, 5th, & 6th years of life	62%	54.4%				
Adolescent Annual Well Care Visits	35%	29.3%				
Pts with Diabetes reaching all goals (Hgb A1c <=8; BP <130/80; LDL <130; ASA use; Tob free	7%	11.7%	15%	11.9%	28%	15.5%
Diabetes Optimal Care (Revised) - HgbA1c <=7.0; LDL <100; BP <130/80; ASA use; Tob free					14%	5.9%
Pts with Diabetes - HgbA1c <=8			66%	64.0%	81%	62.3%
Diabetes HgbA1c (revised) <= 7.0					69%	41.8%
Pts with Diabetes-BP <130/85			49%	42.8%	61%	41.7%
Diabetes BP (revised) <130/80					52%	32.3%
Pts with Diabetes - LDL <130			66%	60.1%	60%	62.9%
Diabetes LDL (revised) < 100					47%	37.9%
Pts with Diabetes - ASA use			56%	67.8%	89%	60.3%
Pts with Diabetes - Tobacco Free			73%	69.2%	79%	63.6%
Pts with diabetes receiving a retinal eye exam	64%	60.2%	58%	56.0%	71%	55.9%
Pts with diabetes receiving Nephropathy screening	68%	65.6%	65%	58.5%	66%	58.1%
High Blood Pressure Treatment (BP <=140/90)	42%	57.0%	53%	60.4%	60%	64.1%
Breast Cancer Screening (age 50-69)	77%	76.2%	76%	75.3%	75%	78.0%
Cervical Cancer Screening (age 18-64)	82%	76.1%	82%	77.8%	84%	82.0%
Chlamydia Screening in women (ages 16-25)	8%	26.4%	15%	29.1%	18%	31.7%