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Raising the Bar for Quality

Introduction

For 54 years, Kaiser Permanente (KP) has participated in the development of high-quality, cost-effective, integrated health care delivery in the United States—first as a pioneer of prepaid medical care, then as a leading health maintenance organization (HMO), now as the nation's largest not-for-profit managed care organization.

In 1994, drawing talent from the Permanente Medical Groups (PMGs) and Kaiser Foundation Health Plan/Hospitals (KFHP/H), a unique quality oversight and improvement program—the Medical Directors' Quality Review (MDQR)—was developed. Now in its fourth year of implementation, the MDQR has not only contributed to the outstanding record we have established with the National Committee for Quality Assurance (NCQA), but has changed the way we structure and implement quality assurance and improvement across KP. The MDQR combines a quality improvement orientation, a standards-driven survey process, audits of records, and peer consultation to implement national quality assurance standards that are among the highest in the nation.

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The MDQR was first implemented under the direction of the Medical Directors' Quality Committee (MDQC) in 1995. As an agent of the MDQC and the KFHP/H Boards' Quality and Health Improvement Committee (QHIC), the MDQR is different from traditional corporate and board of directors' oversight processes in three important ways:

1. The MDQR is a shared process, directed and coordinated by leaders representing both the PMGs and KFHP/H.
2. The MDQR is based on standards that have been developed and refined by quality leaders representing every Health Plan and Medical Group across the KP Program.
3. The MDQR is conducted by trained peer reviewers—clinicians as well as quality assurance professionals—who apply direct experience from their daily work to the processes they review.

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Unlike many quality oversight activities, a high degree of candor and constructive feedback predominates as physicians, nurses, and other quality assurance professionals discuss their findings and provide peer consultation onsite. As a peer review process, the MDQR is conducted in accordance with peer review statutes to assure confidentiality and legal protection for findings. The findings are reviewed by the MDQC and are used to inform the QHIC, which then provides an independent assessment of the survey results.

History of Formal KP Quality Assurance Programs

Formal quality assurance activities, designed to "measure and minimize variations from what is considered desirable based on current knowledge,"[1] emerged as early as the 1960s within The Permanente Medical Group (TPMG) of Northern California with the advent of the Comprehensive Quality Assurance System (CQAS).[2] Similarly, formal quality assurance programs arose in the Southern California, Northwest (Portland), and other KP Regions. As these programs grew in sophistication, they played an important role within KP and contributed to the national evolution of quality assurance. For many at KP, however, the primary focus became compliance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inpatient standards, as was the case in much of the health care community.

In the late 1980s, consumers, regulators, and purchasers began to question the health care industry's ability to provide effective oversight through its traditional internal mechanisms. Consequently, various health care "watchdog" groups emerged, regulators began to toughen their oversight, and the purchaser-sponsored NCQA rose to prominence.[a]

History of the KFHP/H Boards' Quality and Health Improvement Committee (QHIC)

In 1983, the KFHP/H Boards formed a quality subcommittee—the Boards' Committee on Quality of Care (BCQC)[b]—in response to heightened awareness by members of the KFHP/H Boards of their fiduciary responsibilities,[3] especially as they related to quality.[c]

In 1983, intending to vigorously exercise these duties and responsibilities in the best interests of those served by the Program, the BCQC began to conduct onsite quality review visits periodically (ie, every 12-18 months) to the KP Regions (nine in 1983, expanded to 12 by 1986). The threefold objective of the quality review visits was to evaluate KP Regions' quality structure and processes, to ensure that leadership was performing its role, and to exercise the Boards' responsibility to assure patient safety.

The Boards' annual reviews continued through the early 1990s and led to continued improvement of the KP Regions' quality processes and infrastructure. However, these efforts neither inspired the rapid improvement necessary to meet growing expectations (of consumers and others) nor led to the improvement needed for compliance with NCQA requirements or Health Plan Employer Data and Information Set (HEDIS) performance measures.

SHARON CONROW, DrPH (not pictured), is the KFHP/H VP for Quality Systems. She codirected the MDQR from 1995 until July 1998 in her role as KFHP/H VP for Quality. She worked for SCPMG for 11 years, prior to assuming her position at Program Offices in 1992. ROB FORMANEK, MD, is the MDQR Medical Director for The Permanente Federation. He has codirected the MDQR since its inception in March 1995. Prior to his work with the MDQR, he was the TPMG Quality Improvement Director in Northern California.

Mutual Accountability, Permanente Medicine, and the Medical Directors' Quality Committee (MDQC)

In 1994, David Lawrence, MD, Chief Executive Officer of KFHP/H, asked the PMG Medical Directors to propose a new approach to the KP Program's quality review process. In particular, KP Program leaders wanted a process that would foster collaboration between KFHP/H and PMG quality leaders, provide the Boards with the information they needed to continue their oversight responsibilities, and improve quality performance across the KP Program.

In a parallel, related conversation—one that eventually led to formation of The Permanente Federation (TPF)—the value and advisability of autonomy for each PMG was questioned by PMG leaders. Medical Groups could no longer operate in relative isolation within their geographic markets. Any serious breach of quality or performance became national news and touched all PMGs. At issue was the vision of a much closer relationship among the Medical Groups, characterized by performance requirements and "mutual accountability."

Performance requirements—Permanente Medicine[d]—became seen as a necessary and desirable prerequisite to "flying the Permanente flag." However, if the PMGs were to be mutually accountable for performance, an evaluative process would be needed to measure performance and to establish accountability.

Against this backdrop, the MDQC was formed and given its mission to develop and implement "a quality review structure and process that in its actualization will help ensure and improve the quality of care and service to Health Plan members and other customers." Although not readily apparent from its name, the MDQC was composed of KFHP/H as well as PMG representatives.[e]

Eight standards were developed by the MDQC in late 1994, and four of these were implemented in 1995 by reviewers for the new MDQR quality review process. The name MDQR was selected to emphasize the Medical Directors' commitment to national quality standards for all PMGs. This commitment represented a substantial change in policy and culture from the individual group autonomy practiced since the 1940s.

Standards were crafted as "stretch goals" that might not be universally achievable for some time but that established the vision for quality structure, process, and accountability. The development and implementation process harnessed the energy and commitment of the KP quality assurance community as nothing else had done; the standards were challenging and intended to support superior performance. Accountability was expected, but it was accountability based on a learning model instead of an enforcement model.

Since the inception of the MDQR, more than 100 KP quality assurance professionals and physicians have been trained as MDQR surveyors. The training is a rigorous process that extends over two days. Surveyors volunteer their time, energy, and expertise to be trained and to participate in one or two surveys per year. Almost without exception, they report the process to be personally and professionally rewarding, both for what they can offer colleagues and for what they take away from each survey.

Implementation of the Medical Directors' Quality Review

Joint responsibility for directing the new quality reviews was assigned to Sharon Conrow, Vice President for Quality at KFHP/H; and Rob Formanek, MD, of The Permanente Federation (TPF).[f] In 1995, the two worked closely together with Kathy Antis of the Department of Care and Service Quality, Diane Hedler of TPF, and others in the MDQR Work Group[g] to design and prepare the quality review process for implementation.

The MDQC originally developed eight standards:

- Quality Systems Standard;
- Continuity of Care Standard;
- Affiliated Care Standard;
- Qualifications and Competency of Health Practitioners (QCHP) Standard;
- Risk Management Standard;
- Member Rights and Responsibilities (MRR) Standard;
- Utilization Management Standard; and
- Performance Assessment Standard.

Initial quality reviews were conducted in 1995 for each of the 12 KP Regions.[h] In 1996, 14 quality reviews were conducted; one each for the 12 KP Regions reviewed in 1995, one for Community Health Plan (CHP) in the Northeast, and one for an additional non-KP health plan that was under consideration for merger or acquisition.

On the basis of the 1995 finding that peer review processes varied greatly across the KP Regions and within the PMGs, in 1996, a work group composed primarily of Permanente physician leaders crafted a ninth standard: the Practitioner Performance Review and Oversight (PPRO) Standard. Like all MDQC standards, this standard aimed to represent the ideal. It was also intended to "raise the bar" for quality assurance across the PMGs and all parts of the KP Program.

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Similarly, other expert work groups were formed to improve credentialing practices and to improve the management of quality in affiliated (contract) relationships such as physician networks. An audit process using sampling techniques was designed and implemented in cooperation with the KFHP/H Internal Audit Department to provide quantitative data about the completeness of credentials files. The information obtained through the 1997 audit process identified several areas of underperformance. These areas have now been improved to acceptable levels, and the degree of improvement has been quantified by additional audits in 1998.

In 1996, Terri Kielhorn, JD (of the KFHP/H Department of Care and Service Quality) and Andy Wiesenthal, MD (of the Colorado Permanente Medical Group) led KP Program risk management experts in an extensive effort to achieve agreement on data specifications and processes. As obvious as it may seem, such agreement has in the past been elusive. The work was codified in the revised Risk Management Standard. Because of this standard, we are now able in 1998 to compare performance data for risk management activities across the entire KP Program. Long overdue, this ability to compare is a historical first for risk management. Starting in 1997, a work group developed KP guidelines for proctoring and privileging, and these will be assessed in 1999 as part of the QCHP Standard.

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MDQR Redesign

True to the principles of continuous quality improvement, the members of the MDQC[i] are themselves currently in the midst of a determined effort to reinvent and streamline the MDQC functions and the MDQR process. Changes for 1999 include:

- Adding a data table for each standard to enable more objectivity in assessments and recommendations;
- Incorporating data requirements to parallel and support care management efforts across the KP Program as guided by the Care Management Institute;
- Realigning the MDQR standards with changes in external regulatory and accreditation requirements, such as those of NCQA and the Health Care Financing Administration (HCFA);
- Combining components of the Affiliated Care Standard into other standards;
- Streamlining the remaining standards by eliminating redundancy; and
- Addressing management accountabilities and the significant event identification and correction process in the standards.

"Nothing quite like the MDQR exists in any other managed care program."

Summary

The MDQR is designed to improve and bring consistency to quality management practices, to our collective performance, and ultimately to the quality of care and service provided to our members. The MDQR draws its strength and richness from participation of the many quality assurance professionals and physicians who generously volunteer their time, energy, and expertise. Obviously, the success of the MDQR directly involves reviewers and reviewees. Not so obviously, but of even greater importance, the MDQR can only achieve its mission by the work of the many committed clinicians and other health care professionals within the KP system—those who directly care for and serve our members.

Nothing quite like the MDQR exists in any other managed care program. It represents our best effort to establish a model for quality oversight while embedding within it the capability to stimulate learning and set the stage for continuous improvement. ❖

[a]With participation from KP quality assurance leaders, the National Committee for Quality Assurance (NCQA) was guided in its creation in 1980 by the Group Health Association of America (GHAA) and the American Association of Foundations for Medical Care (AAFMC). This effort was in response to a request by the federal Office of HMOs. The original Board of NCQA, in addition to representatives from group practice prepaid plans and independent prepaid practice associations, had consumer and business representatives. Over time, NCQA has become the primary national accreditation agency for managed care organizations.

[b]The KFHP/H Boards' quality subcommittee was renamed the Boards' Quality Committee (BQC) in 1995 and in 1997 was given its current name: the Boards' Quality and Health Improvement Committee (QHIC).

[c]These responsibilities include provision of a safe physical environment as well as proper equipment and resources for patient care; internal policies and procedures that protect patients and members; proper selection and retention of KFHP/H staff; and reasonable measures taken to guarantee the administration of sound patient care.

[d]These performance requirements were initially spoken of as Permanente Practice and more recently as Permanente Medicine.

[e]Members of the MDQC in 1994 included Sharon Conrow, DrPH, KFHP/H VP Quality; F. Jay Crosson, MD, TPMG; David Lawrence, MD, KFHP/H CEO; Ian Leverton, MD, PMGIS; Don Neilsen, MD, PMGIS; Larry Oates, MD, MAPMG; Ron Potts, MD, OPMG; Richard Rodriguez, MD, TSPMG; Al Weiland, MD, NWP; Andy Wiesenthal, MD, CPMG; and Les Zendle, MD, SCPMG.

[f]The Permanente Federation (TPF) did not exist in 1995. Its predecessor, the Permanente Medical Groups Interregional Services (PMGIS), was renamed Permanente Interregional Consultants (PIC) in 1996, and in 1997 PIC was replaced by TPF. The KFHP/H Department of Care and Service Quality is the current name for the former Department of Quality at KFHP/H.

[g]Currently, members of the MDQR Work Group include Kathy Antis, RN, DCSQ; Tracey Cameron, MBA, TPF; Barbara Elenteny, RN, PhD, DCSQ; Rob Formanek MD, TPF; Sharron Garvisch RN, DCSQ; Diane Hedler, RN, TPF; Terri Kielhorn, JD, DCSQ; and Jed Weissberg, MD, TPF.

[h]The 1995 Ohio MDQR was conducted in January 1996; the 1996 Ohio MDQR was conducted in August 1996.

[i]Current members of the MDQC include Kathy Antis, DCSQ (acting); Dick Barnaby, KP-California Division; Rob Formanek, MD, TPF; Bill Gillespie, MD, DCSQ; Diane Hedler, RN, MS, TPF; Phil Madvig, MD, TPMG; Larry Oates, MD, MAPMG; Bruce Perry, MD, TSPMG; Patricia Siegel, RN, MS, KP-California Division; Jed Weissberg, MD, TPF (chair), TSPMG; Andy Wiesenthal, MD, CPMG; and Les Zendle, MD, SCPMG.

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1.Rubin L. Quality assurance, integral to management. Address given at Medical Group Management Association International Congress on Group Practice, April 23, 1985, Dallas, Texas.

2.Rubin L. Comprehensive Quality Assurance System: the Kaiser Permanente approach. Alexandria, VA: American Group Practice Association; 1987.

3.The Board's responsibility for assuring quality care. An American Hospital Association briefing paper for hospital governing boards, July 1987. Chicago, Illinois: American Hospital Association; 1987.

MDQR reviewers, 1995-1998			
Name	**Location**	**Name**	**Location**
J D Adams	Georgia	Charles Kellerman, MD	Southern California
Deborah Adles	North Carolina	Sandy Kick	Northern California
Andy Amster	Southern California	Maureen Krone	Northeast
Pam Anderson	Mid-Atlantic	Vicki Lewis	Southern California
Ann Beach, MD	Georgia	Bill Likosky, MD	Northern California
Anna Bergstrom	Colorado	Sally Ling, MD	Kansas
Martha Blake	Northwest	Jan Loewen	Northwest
Preston Blomquist, MD	Texas	Thom Love, MD	Texas
Pam Boeck	Group Health Northwest	Stacy Lundin, MD	Northeast
Edward Bordin, MD	Mid-Atlantic	Margaret Lyngholm	Northeast
John Brookey, MD	Southern California	Joe Macaluso	Northern California
Margaret Brown, MD	Mid-Atlantic	Nancy Maranville	Group Health Cooperative
Maria Capaldo, MD	Southern California	Joe Marino, MD	Ohio
John Charde, MD	Northeast	Bill Marsh, MD	Colorado
Stan Cias	Southern California	Reginald Mason, MD	Georgia
Adrienne Cotterell	Southern California	Andrea McHugh	Northeast
Kathleen Cromp	Group Health Cooperative	Sharon Mesker	Southern California
Gary DaMert, MD	Ohio	Harry Miller, MD	Northeast
Nancy Denson	Group Health Cooperative	Nancy Murphy	Northeast
Fred Drennan, MD	Group Health Cooperative	Larry Oates, MD	Mid-Atlantic
Jack Dutzar, MD	Group Health Northwest	Karen Oshiro	Hawaii
Melody Fanning	Hawaii	Bud Pate	Southern California
Joel Feinman, PhD	Northeast	Bruce Perry, MD	Georgia
Trish Ford, MD	Northeast	Ron Potts, MD	Northwest
Eric Furman, MD	Texas	Phyllis Powell	Ohio
Geoff Galbraith, MD	Hawaii	Kathy Raasch	Northern California
Suzanne Graham, PhD	Northern California	Michael Raggio, MD	Colorado
Cynthia Hartman	Northern California	Michael Ralston, MD	Northern California
Lynn Harris	Northeast	Lister Robinson	Texas
Arthur Hayward, MD	Northwest	Denise Runde	Northern California
Nancy Henley, MD	North Carolina	Susan Senecal	Northeast
Judy Hopkins	Georgia	Connie Slaughter	Colorado
Ellen Hughes	Southern California	Jack Varonin	Northern California
Steven Hull, MD	Kansas	Karen Vournas, MD	Northeast
Joel Hyatt, MD	Southern California	Barbara Walter, DO	North Carolina
Dorothy Jackson	Colorado	Cheryl Wescott	Kansas
Caleb Jawhar	Mid-Atlantic	Andy Wiesenthal, MD	Colorado
Iris Johnson	Northwest	Ronald Williams, MD	Group Health Cooperative
Tom Judd	Georgia	Del Young, MD	Mid-Atlantic
Lynne Jung	North Carolina		

What is the Value of the Medical Directors' Quality Review (MDQR)?

The following comments from Program leaders as well as MDQR reviewers and reviewees capture some of the reasons that Kaiser Permanente continues to be committed to the MDQR:

"It was one of the best reviews I've observed. The team members were insightful, and I was impressed by the way they conducted it. They weren't adversarial, and ideas from other Divisions were shared in a way that helped us do our work better."
— Richard Topel, MD, Golden Gate Service Area, The Permanente Medical Group

"The MDQR is a good way to achieve internal improvement while maintaining readiness for external reviews. It assists sites with preparing for NCQA and JCAHO by pointing out areas in need of improvement. Without the MDQR, it would be tougher trying to catch up just before an external review. KP standards are sometimes higher than external standards and should be."
— Maria Capaldo, MD, Southern California Permanente Medical Group

"The MDQR provides leadership in areas not well covered by NCQA, such as the MDQR standards related to risk management and continuity/coordination of care."
—Tom Judd, The Southeast Permanente Medical Group

"The MDQR is one of the major benefits in our affiliation with KP. The credentials files audit has been very helpful."
—Nancy Maranville, Group Health Cooperative

"The MDQR helps to characterize us as a proactive, learning organization. It is one of the unique competencies that distinguishes KP from the competitors."
—Gary DaMert, MD, Ohio Permanente Medical Group

"The peer interaction is great. As surveyors, we usually depart from the review site with more insights and new ideas than we've delivered."
—Michael Raggio, MD, Colorado Permanente Medical Group

"The MDQR provides an opportunity to share best thinking on issues and to set our own standards. The face-to-face interactions between peers are most effective in moving good practices around."
—Al Weiland, MD, Medical Director, Northwest Permanente

"The MDQR is key to improving our quality, which lies at the heart of our mission, our financial recovery, and how to compete."
—David Lawrence, MD, Chief Executive Officer, Kaiser Foundation Health Plan/Hospitals

With all your science, can you tell me how it is, and whence it is, that light comes into the soul?
Henry David Cook