By Bruce Perry, MD, MPH

A Word from the Medical Directors

Harvesting the Wealth of Science and Permanente Clinical Wisdom: The Importance of Strategic Clinical Improvement

In the Spring edition of *The Permanente Journal*, Dr. Peter Juhn and his colleagues reported on the development of the Kaiser Permanente (KP) Care Management Institute (CMI). In this Editorial, I want to underscore the importance of CMI and its landmark work in support of this organization's strategic clinical improvement. The future competitive success of KP will indeed rest on the ability of our organization to rapidly implement improvements throughout the KP Medical Care Program.

Growth and Direction of Clinical Improvement Efforts

As a physician-manager and quality consultant for the past 15 years, I have had the opportunity to witness the growth of clinical improvement activities in multiple organizations. Clinical improvement initiatives emerged as a result of using the tools and techniques of total quality management as well as those of department- or team-based quality assurance strategies. Many organizations with which I have worked have been quite effective in stimulating small groups of clinicians to develop clinical guidelines or clinical projects.

Decentralization Doesn't Work

At the beginning of this decade, unfortunately, many organizations took a diffuse, decentralized approach to improving clinical quality. I believe that three major problems are inherent in the decentralized approach: First, small teams or departments may not have had available to them all the scientific evidence necessary to develop their activities or guidelines and at times did not base their interventions on the best scientific evidence even when it was available. Initiatives beset with this flaw were doomed from the beginning. Second, the decentralized approach permitted local quality improvements but did not encourage dissemination across the organization; consequently, outcomes did not improve. (For instance, a successful asthma intervention program in one part of the organization could not be implemented in other parts of the organization.) Third, the decentralized approach led to multiple conflicting activities that emphasized resolution of disputes more than they emphasized organizationwide implementation. Multiple guidelines for managing lower-back pain or diabetes were not unusual in organizations. I have quipped that if an organization stimulates multiple clinical initiatives in local areas without giving these initiatives focus, then a "thousand points of light" rapidly turn into 500 cannons firing at other parts of the organization! Clearly, a decentralized approach is not the direction we need.

Successful, Centralized Approach to Clinical Improvement

Organizations—including the Permanente Medical Groups—have learned what characteristics of successful programs have led to sustained clinical improvement. Since 1992, for instance, Group Health Cooperative of Puget Sound (GHC) has used the "clinical roadmap" concept—condition-specific, organizationwide clinical improvement projects—and has subsequently shown consistent improvement in several clinical areas. Over a five-year period, for example, GHC increased secondary prevention among persons who have had a cardiac event from a baseline of 38% (in 1994) to 64% of postmyocardial infarction patients whose low-density lipoprotein (LDL) levels were <130 mg/dL (Michael E. Stuart, MD, personal communication, May 1998).* Lovelace Clinic has shown an 84% decline in lost school, daycare, and workdays among asthmatic children and a statistically significant improvement in mean glycemia levels among diabetic patients—a decrease of 12.2% to 9.9% during a two-year period of two years.[1] In The Southeast Permanente Medical Group, the number of hospital admissions for asthma has been reduced 75% from the number recorded five years ago.[2] In the Southern California Permanente Medical Group, use of ionic and nonionic contrast media was rationalized through the Clinical Guideline Project (Allen E. Bredt, MD, personal communication, May 1998).† Clinical improvement programs with certain characteristics and components can thus be shown to improve outcomes effectively on an organizational level.

Components of Successful Programs

Successful programs for clinical improvement share several common characteristics:

1) Strong commitment from senior management;
2) Organizational investigation of multiple implementation strategies and subsequent identification of strategies most appropriate for particular interventions;
3) Sharing of resources, rewards, and incentives across the organization;
4) Foundation on scientific knowledge for conditions which have therapeutic breakthroughs that may lead to better clinical outcomes;
5) Sound, scientifically based outcome measurement systems and automated feedback systems.

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In some Permanente Medical Groups and elsewhere, these robust Clinical Improvement Programs have been called Disease State Management. (I actually prefer the term "care management" because it is more comprehensive.) Regardless of the nomenclature used, these programs share several common components:

1) Solid guidelines based on thorough review of scientific evidence;
2) Sound measurement strategies accompanied by outcome targets;
3) Reliable intervention (eg, education, computerized feedback, and decision support at the time of care);
4) Application of the best, most current knowledge of patient education methods and development of multiple patient education strategies to involve consumers in their own care;
5) Development of new models of care, such as that featuring the Diabetes Case Manager (shown to be effective in the Northwest Division).

CMI: Integrating Successful Approaches to Clinical Improvement

In late 1996 and early 1997, I participated in the National Partnership Agreement Group, which suggested a methodology for improving clinical outcomes across the entire Program and specifically formulated the CMI. We believed that during a long history of being able to improve care, the Permanente Medical Groups have developed great expertise. If we could develop clinical improvements synergistically and learn how to successfully implement ideas across the Program, we would be at a distinct competitive advantage. In discussing the formation of CMI, we realized that many KP Market Areas had multiple projects addressing asthma, diabetes, and other common clinical problems. We questioned why multiple teams were performing the same function (eg, developing evidence tables and guidelines). This diversified approach to developing and implementing guidelines and clinical improvement efforts confused regulators, employers, and our members. Members of the National Partnership Agreement Group believed that if we could accomplish these functions once—at a national level—and that if we understood implementation strategies well at the local level, we could consistently and rapidly improve clinical outcomes across the country. With this goal in mind, we proposed the Institute.

I welcome the efforts of the CMI. As one of its authors, I am pleased with its progress to date. I believe that several key characteristics of the CMI are important for our success:

1) CMI is a joint activity of the senior leadership of the Federation and the Kaiser Foundation Health Plan nationally;
2) CMI has gathered the expertise to base interventions solely on scientific evidence;
3) CMI staff actively seek involvement of clinical improvement leaders from all Medical Groups;
4) CMI is actively searching for best practices from each Medical Group;
5) CMI is performing cutting-edge work in learning about implementation strategies so that nationally developed programs can be adopted and implemented locally. The implementation network, the learning teams, the fund for assisting implementation, and the website are all tools that contribute to this cutting-edge work.

I contrast the robust activities of the CMI with those of insurance companies, which develop guidelines by involving only a handful of clinicians, implement programs heavy-handedly, and provide no strategies for local implementation. The Permanente Medical Groups can and will do it better.

In light of a real need for a strategic clinical improvement strategy within The Permanente Federation, and because of the lessons learned from successful disease state management—as well as because of the competitive world in which we must thrive—as a Medical Director, I wholeheartedly endorse the Care Management Institute. The Institute is a way to harvest the wealth of science and Permanente clinical wisdom, which will allow us to surpass other health care organizations in the next millennium. ❖

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† Southern California Permanente Medical Group, Panorama City, California.

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1. Do it yourself disease management programs. Med Manage Network 1998 Feb;6(2):1.
2. Quality Improvement Analysis Asthma Program. Atlanta, GA: TSPMG, 1998.