

# Connecting CME to Quality Improvement: What You Need to Know



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## Introduction

For decades, the US healthcare system has been compromised by well-documented deficiencies in quality resulting in exorbitant costs. The literature describing US health care is replete with evidence of inadequate technological infrastructure, gaps in accountability, and severe fragmentation of the system. Numerous studies have shown that although the US spends more than any other industrial nation on health care, we continue to lag on important indicators of quality and patient outcomes. Given that many common chronic conditions are attributable to poor health behaviors, it is especially problematic that most of our healthcare costs are for direct medical care rather than focus on addressing underlying health behaviors. In response to the dire status of our healthcare system, promising national initiatives are underway, many in

association with the Affordable Care Act (ACA) of 2010. These initiatives aim to provide more Americans with high-quality health care, to decrease costs, and to ultimately improve patient outcomes. The ACA includes provisions and incentives for US healthcare professionals to contribute to the Department of Health and Human Services (HHS) National Quality Strategy, defined by the following 6 priorities: <sup>1</sup>

1. Patient safety
2. Coordination of care
3. Patient and caregiver engagement
4. Population and public health
5. Efficient use of healthcare resources
6. Dissemination of best practices

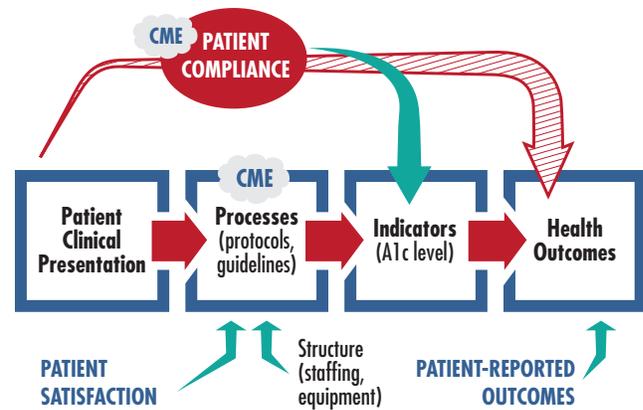
To achieve goals targeted by these priorities, the federal government and many healthcare organizations are in the process of instituting new payment, transparency, and professionalism programs. In essence, payment for care is no longer quality neutral, with stakeholder compensation based on outcomes and not activity or volume. As such, the focus has shifted to driving value-based care, and in order to demonstrate value one must achieve certain quality standards. Consequently, these pressures and changes have also started a chain reaction to consolidate the fragmented system (approximately 2 in 3 physicians are now employed) and re-think new business models of care such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs).

As a response to the *changes* in the healthcare industry, CME organizations and supporters of CME possess an incredible opportunity to demonstrate the true impact of education on improved quality of care and possibly cost savings. However, organizations must a) shift their training programs from one focused on the individual to one that is focused on the system and b) base new quality improvement models on essential elements that are accepted and scalable. Below we offer a framework to assess and measure quality improvement initiatives and describe the critical components of successful quality improvement projects.

## A Framework for Measuring Quality Improvement Initiatives

To successfully evaluate quality improvement, organizations must adopt a new way of thinking of measuring success. Quality measures used in quality improvement initiatives are by definition multidimensional and should take into account organizational, process, outcome, and patient measures (Figure 1). The framework described in Figure 1 illustrates the value chain for deriving quality improvement and the various levels of measures that are critical and necessary to capture before, during, and after a program. Treatment decisions and the outcome of those decisions are influenced by *processes of care* (eg, services delivered), *structure* of the delivery system (eg, staffing, equipment, facilities), and *patient compliance* (eg, adherence to recommendations). Interventions that target these elements will have a higher probability of improving quality indicators (eg, biological measures) and health outcomes (eg, actual results of care). When measuring QI programs, many factors must be taken into account to accurately isolate the effect of the interventions. Measures should be associated with the parts of the value chain model. There are many forms of data to help identify and document measures across the value chain model, including registries, claims data, clinical data from charts, and pharmacy data. Considerations of data source and measures must be taken into account early in the process when designing a quality improvement initiative.

Figure 1. Value Chain Model for Measuring Quality Improvement Initiatives<sup>2</sup>



## Components of Successful Quality Improvement Educational Projects

Fundamentally, supporters of quality improvement projects have already embraced their value for sustaining practice change through medical education; however, supporters have not identified the necessary ingredients. According to the American Medical Association (AMA), improved patient outcomes depend on successful quality improvement programs, which incorporate training on the quality improvement process and its application to best practices in patient care.<sup>3</sup> In developing such programs, healthcare systems can adopt and adapt models of quality improvement that have been established in other professional areas. These models include Six Sigma, Continuous Quality Improvement, Total Quality Improvement, and Lean Six Sigma. Below we describe essential elements of established quality improvement models, highlighting their educational components.

First, quality improvement educational projects should align with the organization's goals.<sup>4</sup> A goal-focused approach is essential for evaluating the validity of such projects. From this model, a set of benchmarks can be established to consistently measure the accountability among all proposed educational projects.

Second, sets of measures are needed at all levels (value chain model) to establish a baseline and compare results to determine improved health services and outcomes of individuals and populations.<sup>1</sup> According to the Agency for Healthcare Research and Quality's Health Resources and Services Administration (HRSA), data is the cornerstone of quality improvement.<sup>4</sup> Proposed quality improvement models should include objective, validated data sources that describe how well systems are working and what happens when changes are applied.<sup>4</sup> Appropriate use of data enables measurement of whether and to what degree implemented changes in practice lead to intended improvements. In addition, a data-driven approach allows comparisons of performance changes across individual healthcare clinicians or groups. This approach enables educational projects to achieve levels 6 and 7 in the widely accepted model of educational outcomes developed by Moore et al.<sup>5</sup> Data should be based on national clinician performance measures or quality indicators, such as those developed by the Physician Consortium for Performance Improvement (PCPI), the Healthcare Effectiveness Data and Information Set (HEDIS), or endorsed by the National Quality Forum (NQF). In addition, data may be derived from metrics established by individual healthcare or member organizations, aligned with their specific goals.

Third, a logic model is needed to identify how measures will be applied to meaningfully assess quality improvement. The logic model should include stakeholder analysis as well as process and protocol reviews. An example is the Institute of Medicine (IOM) logic model addressing the Leading Health Indicators (LHIs) from Healthy People 2020, the nation's 10-year agenda for advancing healthy lives for all.<sup>6</sup> The LHIs are indicators for key causes of preventable deaths and major illnesses in our population. The IOM established a logic model to identify measures of quality for the LHIs in the context of clinical care and public health.<sup>1</sup> Supporters of CME quality improvement projects can apply a logic model to establish benchmarks that will assess the degree to which quality improvement has been achieved.

Fourth, processes need to be established based on nationally accepted standards for correlating CME to quality improvement, such as URAC's Core Standards. URAC is a long-standing, non-profit healthcare accreditation body providing quality benchmarking programs.<sup>7</sup> URAC provides accreditations across a wide range of healthcare organizations, including medical education companies and accredited providers, to validate organizations' commitment to quality improvement and accountability. The federal government, the District of Columbia, and 42 states reference accreditation in state and federal statutes, regulations, agency publications, and requests for proposals or contract language.<sup>7</sup> Organizations maintain URAC accreditation to show compliance with state and federal requirements as well as to validate their ongoing expertise and commitment to quality improvement.

The URAC Core Standards address critical areas of structure and process under which an accredited entity must develop, deliver, and evaluate its services and products. These include organizational structure, staff qualifications and personnel management, internal operations, oversight of delegated responsibilities (eg, educational partners), consumer protection and, ongoing measurement of continuous quality improvement across the business enterprise.<sup>8</sup> As a result, organizations maintaining URAC accreditation engage a system-wide quality improvement program across their deliverables and commit to continued third-party evaluation of their operations.

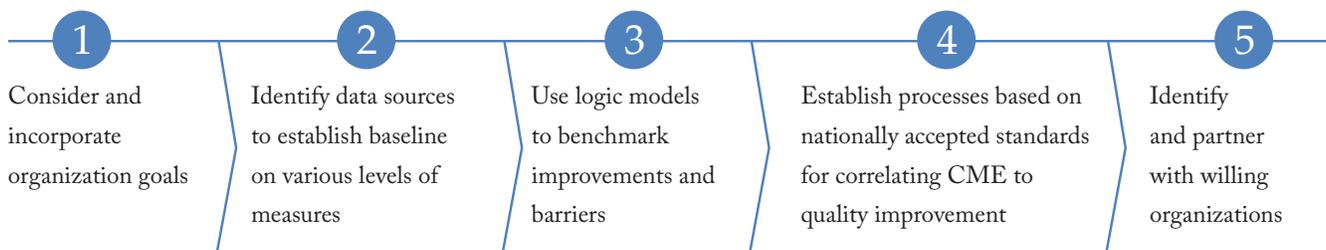
Organizations that commit to quality improvement in their own enterprises and through their partnerships are arguably in a good position to deliver quality improvement projects. They possess validated knowledge, organizational infrastructure, and standard operating procedures to plan, develop, implement, and evaluate quality improvement projects.

Fifth, a successful quality improvement implementation plan benefits from partners in closed systems such as health systems, health plans, or independent physician associations (IPAs) who have access to data. These partnerships help establish and identify gaps at all levels of the value chain

model and can mandate or promote best practices. Because all healthcare delivery is local and therefore, all quality improvement is local, partners have a great incentive to participate in improving their own delivery of care. Under the value-based payment models these groups also have a great financial stake in monitoring and reporting on quality outcome measures.

To summarize, the CME industry has a great opportunity to identify, align, and participate in quality improvement projects in the context of ACA changes. In order for the CME industry to successfully achieve the national goals and priorities, we must incorporate the essential elements of quality improvement in CME programs (Figure 2) and utilize a new framework to determine success (Figure 1).

**Figure 2. Five Essential Elements of Successful QI Implementation**



## References and Resources

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- Other evidence-based archived articles on quality in CME on the Science of CME Web site include:*
- Continuing Medical Education Must Merge with Quality Improvement Programs*, posted March 1, 2013; Available at: [http://primeinc.org/scienceofcme/1085/Continuing\\_Medical\\_Education\\_Must\\_Merge\\_With\\_Quality\\_Improvement\\_Programs](http://primeinc.org/scienceofcme/1085/Continuing_Medical_Education_Must_Merge_With_Quality_Improvement_Programs)
- Building a QI and CME Program*, posted February 16, 2012; Available at: [http://primeinc.org/scienceofcme/953/Building\\_a\\_QI\\_and\\_CME\\_Program](http://primeinc.org/scienceofcme/953/Building_a_QI_and_CME_Program)
- Linking CME Quality and Performance Improvement through ACCME and URAC*, posted June 1, 2010; Available at: [http://primeinc.org/scienceofcme/867/Linking\\_QI\\_and\\_PI\\_-\\_Keynote\\_Address\\_2009](http://primeinc.org/scienceofcme/867/Linking_QI_and_PI_-_Keynote_Address_2009)