INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Working with States

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I. Research and Development Team:

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II. Intent:

The intent of this project is to understand the needs of individual states within the US in regard to challenges they face in health care transformation and how IHI might be a partner in this work with them. A group of us are working with states that received a States Innovation Models Initiative Grant (SIM). These grants are focused on health care delivery system transformation with the aim of improving health system performance. This will allow us to get to a level of detail that gives IHI credibility. Health care transformation at the state level is an enormous undertaking. States have lots of choices for partners. We will make recommendations for IHI's unique role. Assisting states with the execution of this work will provide an important learning opportunity for us.

III. Background:

IHI has worked with States or Regions in the US for a number of years. One of our larger State Based Projects was STAAR which focused on decreasing hospital admissions in three different states: Washington, Michigan and Massachusetts. We have also worked at a national level. Our best-known work was in Scotland to improve the safety of all the Scottish hospitals. In addition, for many years we have been working on the Triple Aim with health care organizations around the world. These organizations have ranged from small organizations covering just 1000 lives to organizations that cover over 10,000,000 lives. We have also done many cycles of research and development work at IHI to support the Triple Aim. During this time we have been building our understanding of what needs to be done in order to manage the Triple Aim for individuals and communities. We have made the most progress with discrete/defined populations such as the members of a health plan or all the employees of a health system. We are gaining knowledge around what works at the community level. This past work will help support our work with states.

Some past research and development work at IHI focused on projects conducted in a political context. The work produced a set of important questions that need to be considered when working with states:

1. Can the project be identified with a political agenda?

2. What else of political significance is going on in the environment (for example, turnover of government officials)?
3. What persons or groups would like the project to succeed or fail for political reasons?
4. What coalition needs to be built?
5. Will there be winners or losers either in the end state or in the transition to that state?
6. What about the success or failure of the project would make a "good story" for the media?
7. What system for relationship management is needed?

Also there is some classic work that others have done that should be taken into consideration when working with states:

Kotter Eight-Stage Process of Creating Major Change
(from Kotter JP. Leading Change. Boston: Harvard Business School Press; 1996)
1. Establish a Sense of Urgency
2. Create a Guiding Coalition
3. Develop a Vision and Strategy
4. Communicate the Change Vision
5. Empower Employees for Broad-Based Action
6. Generate Short-Term Wins
7. Consolidate Gains and Produce More Change
8. Anchor New Approaches in the Culture

IV. Description of Work to Date:

During this cycle of activity we have been working with states and interviewing individuals who are closely linked to state level work. As a reminder we have focused on the following deliverables:

1. Enhance IHI ability to be a credible partner for states.
2. Deepen understanding of state needs.
3. Identify more key faculty to be able to help with state level work.
4. Enhance learning system design/execution model for state initiatives.

V. Results of the 90-Day Scan:

Part 1 Helping states understand how we can partner with them where it makes sense.

Currently we are getting requests from either state governments or associations within individual states to explore how IHI can be a help to them. These request are allowing us to understand state needs and pressures. However, one practical consideration based on interacting with states to date is that they don't know what products and services we are capable of providing. So one simple approach is to divide our offerings along the lines of our strategic priorities: Optimize Health Care Delivery Systems, Population Management, Build Improvement Capability and Patient Engagement. If we can do a better job explaining ourselves to states they will understand better how we can partner together on important pieces of work.

The outline below highlights content areas where we might work with a state:

I. Optimize Health Care Delivery Systems

A. Health Systems and Hospital Systems

1. Focus on cost reduction – this would be based on Kathy's work
2. Safety work at 3 levels- London talk by Carol, Kathy and Roger

a. Calibration #1…Large project, top down ….The Macro approach (Successes, failures and why more is needed)

b. Calibration #2…Mortality…(Using death as a window into the safety of the organization)

c. Calibration #3…Small defects, bottom up…The micro approach (frontline driven safety initiatives)

B. Primary Care- I think our opportunity is to focus on behavioral health integration and primary care. The medical home space is crowded and we need to see where we can uniquely fit in and that is why I recommend primary care and behavioral health integration. More development needed.

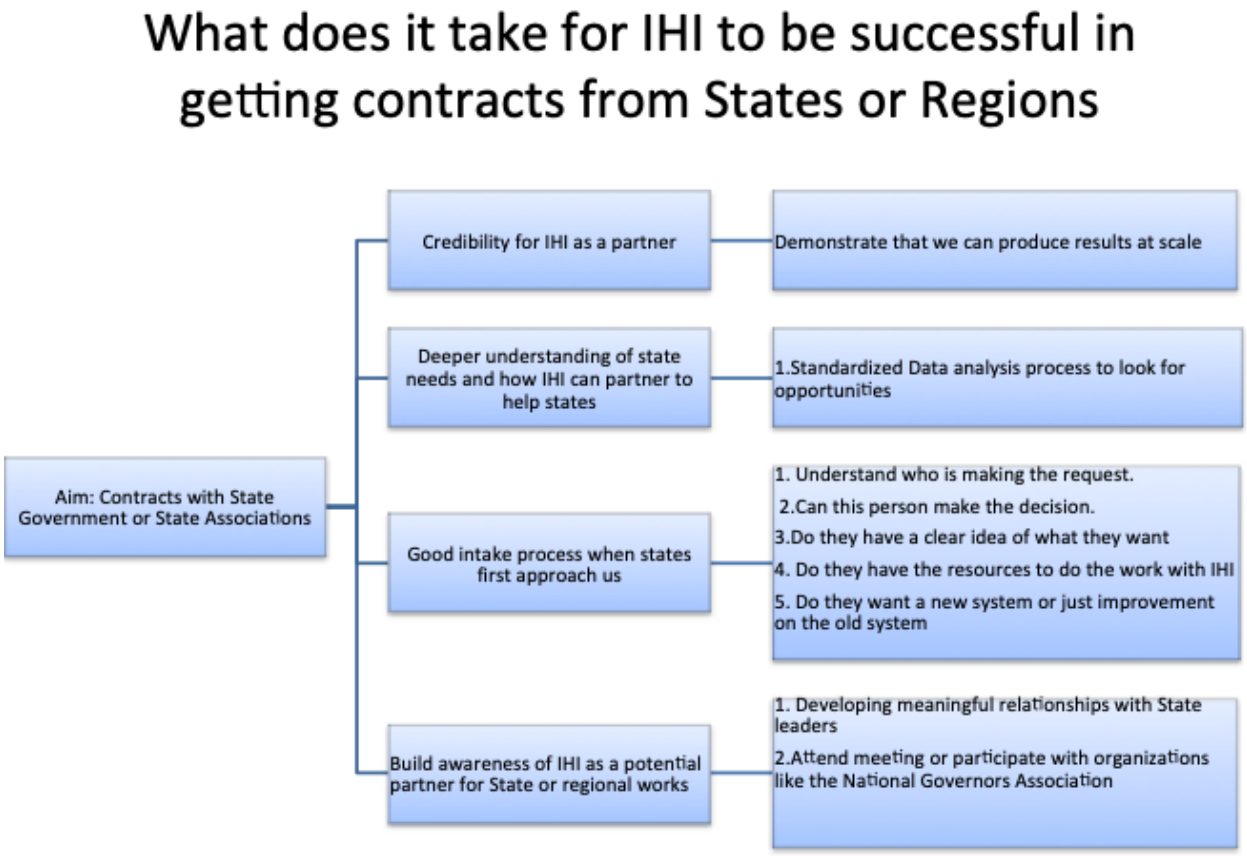
II. Population Management - The focus is on the Triple Aim for populations.

Here we would like to offer a bundled approach around: care redesign, population management, data support, governance, community engagement and patient involvement.

III. Build Improvement Capability

IV. Patient Engagement

The driver diagram below represents some ideas on what we need to do to successfully attract and sign more work with states and regions in the US:



Part 2 Current observations from discussion with individuals.

The following ideas are the observations of a number of individuals from working with states and countries:

1. "Medicaid expects to move from crisis to crisis. When the next crisis arrives the state will deal with it at that time."

2. "At the community level they are not preparing for the influx of Medicaid patients because there is no money in the system for that influx with the ACA. When the patients start coming through the doors the money will follow and they will deal with it at that time"

3. There are a number of partners that you could work with in a state such as the QIO.

4. Getting major programs even started can be hard work. For example, building the CCO in Oregon is a big challenge. Just getting basic structure in place at the CCO to pay the bills is a large undertaking. This level of effort will consume other resources.

5. The competing roles of a state need to be considered. John Colmers in a talk in May said the states have four roles: purchasers, regulators, conveners and market setter/enabler. I think these various roles can cause confusion and mistrust.

6. The Federal system can both help and also disrupt action that is occurring at the state level.

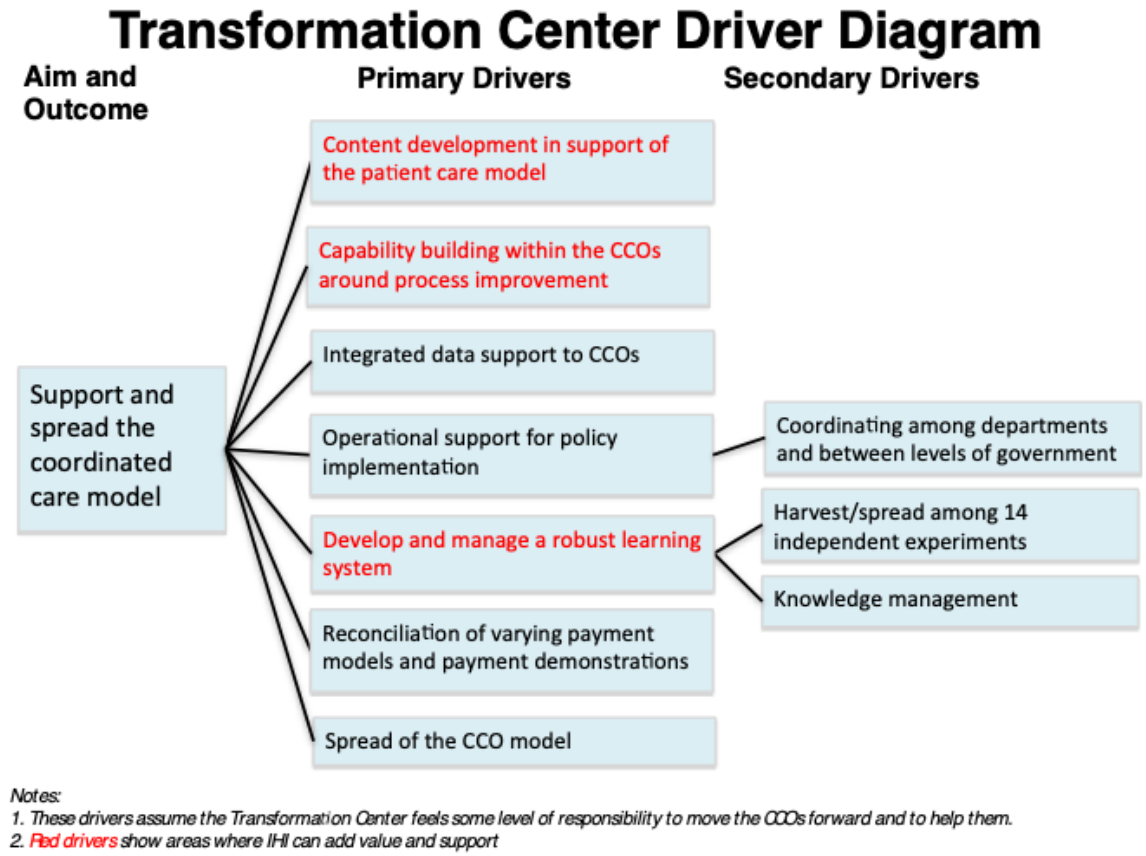
7. Interesting to watch one state group start out thinking that they should focus on per capita cost for their state but quickly realize that would not work in their model and ultimately decide to work on hospital costs. The financial model in some states is not helping change.

8. A couple key observations from Daniel M. Fox, President Emeritus of the Milbank Memorial Fund. In a recent publication Dan wrote, "Governance is a broader concept than government. The definition used in this paper is: in a particular jurisdiction, who does what to, for and with whom to achieve what goals." Also in a recent conversation Dan said, "Reciprocal loyalty is the basis of effective politics."

10. When working with states it is important to work with folks who control budgets and resources. If we don't have their support we will have limited success.

Part Three Working with a state

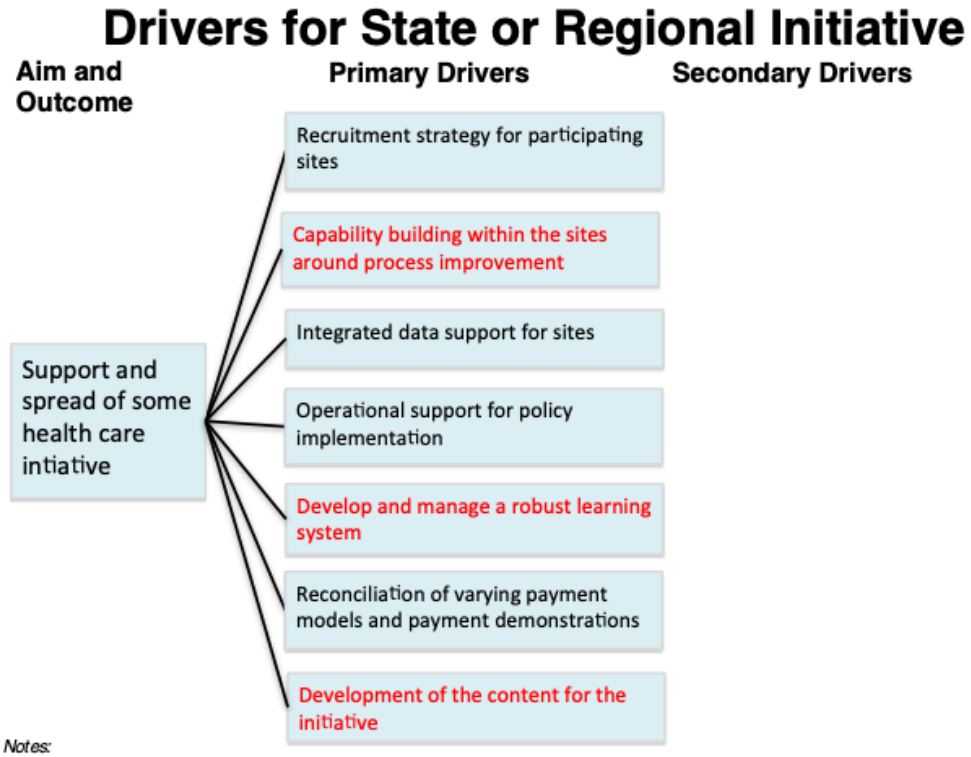
Digesting the above thoughts and further discussion led to the driver diagram below which was used when working with the State of Oregon:



The above driver diagram was created by a team at IHI to help the state of Oregon as it works to improve health care for all of its citizens. It was based on some earlier driver diagrams that were created in the R and D process along with further refinement by the IHI team. An initial focus for Oregon is on their Medicaid population with their 15 Coordinated Care Organizations (CCO). We shared this driver diagram model with a team from Oregon. The drivers in red are where we feel IHI can add the most value. By and large this driver diagram was well received.

Oregon in turn shared with us what they see as some of their key levers:

Based on the interaction and observations, here is a modified version that has applicability to many states as they work on improving health care:



You will notice that an issue that was not considered initially was recruitment strategy for participating sites. The state has basically four functions: "purchasers, regulators, conveners and market setter/enabler." These functions may be at cross-purposes at times making it difficult to easily attract participation. So it is important to acknowledge up front the need to have a recruiting strategy. The state has at least three levers: develop relationships in which organizations see value in non-monetary ways for participation, use financial incentives or force participation through policy changes. Overall the rest of the model has not changed because the rest was well received. There was some discussion about consolidating the drivers around data and operational support for policy, but for clarity at this moment in time they are kept separate.

Why would a state consider IHI to partner with it? We did not directly ask that question on this visit but here are a few observations from our time in Oregon:

First, relationships are important. IHI is well known in Oregon. Governor Kitzhaber knows IHI and has been talking about the Triple Aim for many years. Mike Bonetto is a key advisor in the state and was part of the Triple Aim when he was at Saint Charles Health System. We have worked closely through the years with Care Oregon, which is a well-respected managed Medicaid organization on the Triple Aim.

Second, when people know us well they understand our reputation for quality improvement building and facilitation of collaboratives. We have a track record in these areas.

I think these two areas are what attracted Oregon to consider working with us.

I think a third area is and needs to be a proven track record of results at scale when working in a state or region. We have results from our work in Scotland on safety, large health systems like Kaiser and Ascension and also from our national campaigns on safety in the US. But we need to continue to produce results at scale.

VII. Conclusions and Recommendations:

Working with states and regions in the US is a promising area for IHI. From our work on the Triple Aim we have learned that the frontier for us has been states and regions and we have been learning a great deal by working with them. In the above article we propose a set of drivers that can guide or help states. Lastly, we think there are two things that we need to do to have more opportunity to partner with states: develop relationships with key stakeholders within a state or region and continue to deliver results at the state level when we do have the opportunity to work with them.

VI. Open Questions:

1. How well do we explain IHI to others?
2. Would it be worthwhile to convene a group of policy makers to ask them what policy they can propose that would advance the Triple Aim?