INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Support for Triple Aim Wave 7
4/08

I. Research and Development Team:

- Leader: John Whittington – Contact info: john.w.whittington@ihi.org, 309-454-2093
- Colleague (Helper): Tom Nolan

II. Intent:

In wave 6 of our work on the Triple Aim that was just completed, 4 areas were identified that need further work: policy to support the Triple Aim, testing of our work on primary care and predictive modeling, developing a plan for on-boarding new teams directly into our work and the ability to support external efforts that are promoting the Triple Aim framework. It is the intent of this 90-day cycle to tackle the above issues.

III. Background:

The work of the Triple Aim in the US is being done in an environment that supports a set of nasty dynamics that contribute to a system with high cost and low quality, producing a low-value system compared to other parts of the developed world.

- Supply-driven demand
- Market forces, research methods, and regulatory procedures that assure a steady stream of new technologies that are expensive as a whole but that individually have a limited impact on outcomes
- No mechanism to control cost at the population level, for example a budget for a defined population

- Over reliance on physicians
- No significant foreign competition to introduce new models and spur change (cf Toyota and the auto industry)
- Little appreciation for care as a system or use of system knowledge

We need to describe a set of policies that will contribute to changing the present environment so that the work of the Triple Aim can flourish. These recommendations need to help the Triple Aim Macro-integrator/Accountable entities have incentives to assemble a system that will improve the health of the populations that they are supporting. These policy recommendations need to consider the following questions:

- How should the delivery system be organized at a macro-level?

- What are the economic levers for impacting the health systems that we see around the world today?
- What should we do to impact supply-driven demand? How are incentives out of line currently?
- How do we break monopoly pricing?

In addition to the above the IHI has been working on one or more research topics to support the triple aim during waves 2, 3, 4, 5 and 6. During wave 6 three projects were completed that support the Triple Aim: Predictive Modeling, Primary Care Redesign and Triple Aim Learning and Prototyping. These projects each developed tests that now need to be carried out during this 90 day time period and the results of those tests need to be studied and further action taken based on the results.

We have the opportunity to add more teams to our work. During the last quarter we had three teams that were interested in working with us directly on the Triple Aim. Two of them were added to our teams: New York Presbyterian Select Health and Cincinnati Children's Hospital. We would like to add more teams that fit into the following categories: integrated systems, hospital based systems, state and county initiatives, academic medical centers, safety net providers, social services/cities, public health departments, community based HMO's and businesses. We need a smooth mechanism to on-board these teams so that they can be gaining from and contributing to the work.

Finally we have seen initiatives started by external organizations that have learned about the Triple Aim from the IHI but are not working directly with us. A recent example is an initiative in Minnesota that is encouraging health care systems to commit to working on the Triple Aim and encouraging legislation at the state level that would support the Triple Aim. The IHI needs a mechanism to know about these initiatives and then decide what level of support they might provide to this work.

IV. Description of Work to Date:

Update on key deliverables

1. Develop policy recommendations to support the Triple Aim.

In addition to our planned work for policy, a number of opportunities came along related with policy.

a. Tom Nolan helped with an assessment of states that were being selected for the State Quality Improvement Institute that Academy Health and The Commonwealth Fund have partnered to develop

b. Tom Nolan and Don Berwick are working with Amory Lovins to produce a new health care paper that will help with policy.

c. We worked with John Kitzhaber on a description of the ideal medical system.

d. There was discussion with Paul Ellwood about Triple aim. Dr Ellwood took some early steps to outline policy that would support the Triple Aim

e. We had a meeting with Stuart Altman around the Triple Aim. Because of this meeting we will be getting a summer intern to work on policy with us.

2. Run tests on primary care redesign and predictive modeling based on the work from the last technical briefs.

See Appendix A for a detailed description of the test along with a case example.

3. Create a list of teams to recruit for further work on the Triple Aim. Use the work from wave 6 to determine organizations to recruit.

See Appendix B for a list of recent contacts as potential Triple Aim sites. In addition Carol Beasley has an update list of potential contacts for the Triple Aim

4. Create an on-boarding process for new teams.

An on-boarding process and prospectus have been created. See Appendix for information on the on-boarding process. In addition see the Triple Aim prospectus for phase two which is not attached to this document.

5. Develop an approach to scanning for work being done both internal and external to the IHI on the Triple Aim.

Both Nichole Willy and Nelly Ganesen did work on this from the external scanning perspective. See the Technical Report for further detail about this process.

The internal scanning work was incorporated into portfolio management which was worked on primarily by Lindsay Martin. The work is ongoing

V. Results of the 90-Day Scan:

During this 90 day cycle we ran the following test in brief: Look for the top 10 users of ED. Plot visits over time
and analyze how ED visits could have been avoided through improved Primary Care for these users. Write up a paragraph about each case. The idea behind this test was to work with two concepts: one was to help teams see the value of learning from individual cases and two was to look at how you might decrease ED use. CareOregon shared several examples of cases that they had learned from. The most startling fact was that they estimated over 50% of ED use could be prevented. They based this on the work of the NYU ED Algorithm. Bellin had also estimated that between 50% and 80% of Ed usage could be eliminated. Care South Carolina found one case that had had significant problems related to the fact that a patient had problems getting medication. They were implementing changes in opening up some low cost pharmacy options. Other teams also indicated that they would be doing more analysis.

In April we had another meeting of the Triple Aim teams and the following six observations are from that meeting.

1. The Triple Aim, Macro-integrator, operational definitions and design concepts are ideas that help team organize their work. We still need some tweaking on the design concepts but overall they hold up well.

2. We had an interesting conversation with Bellin in which they suggested that we all work together on decreasing something like ER utilization.

3. Care Oregon provides a wonderful example of what case management should look like, learning from individual patients for the population.

4. Doug Eby has some great thoughts on primary care redesign. He put social/ psychological / support issues equal to or more important than traditional medical diagnosis when he discussed individual cases.

5. Health Partners shared some good data and insights, particularly about having the difficult conversations with specialists around cost.

6. The importance of partnership was evident in presentations and by the fact that three of the organizations had a public health partner in the room with them.

During this quarter we have also been talking with potential new teams. The framework that we are using for the Triple Aim seems to be attractive to these teams. It provides structure but does not tightly bind them to only one way of doing the work.

Finally one quick observation based on interaction with some policy experts: the fact that we have teams actually doing real work on the Triple Aim is important. As we have conversations with them they seem to become more engaged as we share examples of what we have learned from these organizations.

VI. Open Questions:

1. What economic policies do we need to support the Triple Aim?
2. Have we defined well enough the role of the Macro-Integrator to enable them to be successful?
3. Have we described well enough what the medical system needs to look like to support the aim?

VII. Conclusion:

Based on our initial testing using case examples to study ED usage I believe there is further interest in working on decreasing ED usage. ED usage also has the potential to be an intermediate marker of improving the health of the population

VIII: Appendices:

Appendix A: Triple Aim test on decreasing ED use by case studies

Situation:
We would like you to run a test to decrease emergency room use by improving your primary care platform.

Background:
We think that learning from the individual can be terrific and is underutilized. Primary Care redesign is critical to the success of the Triple Aim. Emergency rooms are being over utilized.

Assessment:
The aim of this test will ultimately be measured by decreasing Emergency Room visits.

Recommendation:
In order for you to better understand how your primary care system could be improved we ask that you look for the top 10 users of your emergency room. Plot their visits over time and analyze how these emergency room visits could have been prevented by improvements in your primary care system.

We would like you to share your findings and recommendations with us in a paragraph for each of these 10 patients. You can either post them on our wiki (http://ihitripleaim.wikispaces.com/) on a page that we have created for this or send them to us and we will post the results. We think that there is a lot that we can learn together from this test.

As you do your case studies you might want to think about how you plan to provide services and support in order for your patients to experience the best health possible for them given their genetics, health history, values, etc., and do so with the most efficient use of resources for all participants. You should consider the following design components for primary care.

1. Support for behavioral change to improve health status
2. Coordination of care across boundaries
3. Interpretation and advice on choices to be made, with the patient at the center of decision-making
4. Basic health issues management including prevention and wellness activities that are evidence based
5. Access to the appropriate level of care at the appropriate time
6. Chronic disease management

Structurally you will need to have a clear platform in place for patients to access this service and they will need coordination between all parts so that the system can act as a whole.

Example of learning at the individual level about ED usage

* This first example is interesting because it highlights the role of a managed care plan...out of the box thinking around benefit exceptions that can shift cost.

* Case in point....one of our members was seen in the ED 21 times in Dec.2007, she had a history of heroin use, transportation barriers kept her from receiving Methadone treatment for her addiction and from seeing her PCP on a regular basis. We decided to buy her a bus pass so she could go to the Methadone clinic and see her PCP...there have been no ED visits for two months and she is much more engaged in CD treatment and her PCP relationship (partly due to the relationship our social worker has established with this patient).

* Bus passes are not a part of the typical Medicaid benefit, but what's $23 per month versus $14,000 in Dec. for ED visits!

A case like this illustrates that there are many barriers to care and transportation is one of them. An idea for further exploration would be to understand how prevalent the transportation problem is for this population and what could be done about it.

Appendix B: Recent contacts for the Triple Aim

1. Humboldt County, California March 6

Alan Glaseroff, MD Chief medical Officer, Humboldt-DelNorte Foundation for Medical Care Independent Practice Association

Ann Lindsey, MD Health Officer Humboldt County Department of Health and Human Services

Carol is in contact with them

2. Seattle and King County, Washington March 26

David Fleming

Director of Public Health

Dorothy Teeter

Carol is in contact with them

3. Rhode Island state March 6

David Gifford, MD Director of Health

Dona Goldman, RN, MPH Program Director, Diabetes Prevention and Control Program

Bonnie Zell will follow up with them

4. Alameda County, California April 4

Anthony Iton, MD Director and Health Officer

Bonnie is in contact with him

5. New York City Public Health April 4

Josyln Levy. They are working with New York City Health and Hospital

6. VA April 4

Dr Michael Davies.

Carol will follow back up with them

7. NHSNW (Strategic Health Authority) 4/14/08

Susan Went has been in contact with Mike Ferrar

8. Quad Med/ Quad Graphic April 10

Ray Zastrow.

Carol is in contact. John will make site visit 6/12/08

9. Major Industrial Company April 16,

John is in contact with them. They are considering it.

Appendix C: Tactical plans and goals for the next phase for teams that will be working on the Triple Aim. (This material was written in February and was used in the development of our present Triple Aim Prospectus)

The goals for the next phase of the Triple Aim collaborative

1. Accelerate the progress of the participants on their strategic initiatives related to the Triple Aim
2. Develop innovative services and delivery models to achieve the Triple Aim
3. Learn from working together to continue to build understanding for the Triple Aim

In a very practical sense we would be delighted if teams clearly designate a population that they will work on, have run charts of the 4 to 6 critical measures of success, have a plan for good design elements that they are going to implement and could show how all this connected to the organization's top strategy.

It is our goal to expand the number of teams that are participating with us in the Triple Aim. The IHI has learned much from these present teams but we think the expansion of our work is needed. This should accelerate the learning of the teams and the IHI. The present teams each represent a type of Macro-integrator. These types of integrators can be broken up into a number of segments: integrated systems, hospital based systems, state and county initiatives, academic medical centers, safety net providers, social services/cities, public health departments, community based HMO's, businesses and European teams. We would like to have about five teams per segment.

The next phase overview

1. Identification of teams

The teams we should add must pass three tests: have the Triple Aim as strategic for their organization now or in the next 2 years, be already doing some work that can be considered Triple Aim in type and be willing to commit to designating a population that they would work on, developing run charts of the 4 to 6 critical measures of success, implementing good design elements and showing how all this is connected to the organization's top strategy.

Identification of new teams is now underway. We are seeking recommendations from faculty and we will be seeking recommendations from our present teams along with others who work at the IHI. The question is whether they will provide us enough high quality candidates to expand our teams adequately. Where possible we should seek an introduction to the team by someone who already has a contact with that organization.

2. Interview and recruitment of teams

Interviewing teams needs to be done with some level of structure. During wave 6 we developed a tool that could be used for an interview with potential teams. During the interview we need to introduce the ideas of the Triple aim, assess leadership commitment, understand whether the Triple Aim is or will soon be strategic and see if they have done work that that is Triple Aim in nature.

Working with the IHI on the Triple Aim should be easy for the teams since this is already part of their strategy and our work will just accelerate it.

3. On-boarding each team after recruitment

The informal on-boarding process actually starts with the first two items above but the formal on-boarding will start once a team has been selected. After selection a coaching session will be set up with that team. During the first coaching session the following items will be taught: general review of the Triple Aim, the role of the Macro-Integrator, the need to work with a defined population, and the five design elements. After this we will begin to work together on the site design focus document. There needs to be discussion of the importance of learning from and working with the individuals and the redesign of primary care. We will end this session with discussion about the collaborative: group calls, further coaching, and face to face visits. They should be encouraged to visit other teams if possible. A standardized slide set will be used and this will be presented during the first coaching session using Webex.

4. Supporting each team with a designated faculty coach with at least monthly telephone calls and email interaction

a. Regular communication to understand the team's system

b. Site design focus assistance

Each team will have a coach. A master spreadsheet will be maintained that keeps track of the phone contacts with each team. An attempt should be made once a month to assist the team. The purpose of the call should be to focus on the site design document, helping teams to move this along.

5. Site visit to all teams by their coach if they request it and have an active site design focus document completed including run charts. These site visits will be open to the teams as well but will be limited to 6. Only one IHI faculty will go to any site. IHI Fellows will be welcome to join.

6. A group phone call twice a month revolving around three dimensions: execution, design and measurement

We will continue with our present format of a call twice a month. At least one team should be presenting on a call every time. The team needs to be talking about their population, design elements, measures and progress. They need to explain how this connects to strategy for that

organization. In addition we should continue to have discussion around design elements and measures.

7. One face-to-face meeting for all the teams some time during the course of partnership (This has been changed to two face to face meetings)

This meeting should be an opportunity for the teams to learn from one another. It should be organized around both large group interaction and affinity groups. The affinity groups are the segments of the various types of Macro-integrators. The teams will bring storyboards to present their work. The following topics should be discussed during this session.

1. What we have learned by focusing on the individual
2. Primary Care redesign
3. Measurement strategy
4. Progress on patient empowerment
5. Removing cost from the system
6. Risk and population identification with appropriate strategies for intervention
7. Individual as unit of change
8. Community as target for integration: Who can integrate?

8. The teams will be given the opportunity to participate in the latest IHI R and D projects where applicable.

Teams that are presently participating have been given the chance to do work with us around various pertinent R and D topics. They will continue to receive that opportunity during the next session.

Final notes
1. From an IHI standpoint we have developed most of what the teams need to do this work, however we still need to do more with measurement. We need a broad set of working measures that teams can use. We have some excellent high level measures but some of them are difficult to get often enough and they don't change quickly, for example, health adjusted life expectancy and infant mortality.

2. We need to emphasize the individual as the unit of change and primary care redesign.

3. Lastly, we should employ a pull strategy. When it comes to site visits they need to ask and have a design site focus document with run charts completed before we go.