INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Triple Aim Learning and Prototyping Technical Brief

11/1/07-1/31/08

I. Research and Development Team:

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- Colleague (Helper): Susan Went

II. Intent:

The IHI has developed a model for the Triple Aim. The concept of the Triple Aim is extremely attractive to many organizations. Thirteen organizations are actively engaged in testing this model. We have been learning from these teams. We need to capture knowledge about how to do this work in order to adjust and revise our model as we proceed.

III. Background:

The IHI has been working on one or more research topics to support the Triple Aim during waves 2, 3, 4 and 5. During wave 6 we will be doing four projects: removing waste from specialty care, primary care redesign, predictive modeling, and this project. There remains a critical need to understand in practical terms what is needed to truly improve the Triple Aim for a defined population.

The research for this quarter is based on the following: build a model for the Triple Aim, test the model, consolidate the learning, and revise the model. During this 90-day period, we have to consolidate our learning.

The strongest work within teams that are partnering with the IHI centers around improving health experience along with the health of the population. The issue is how to get work that centers on controlling the growth of per capita health care spending. Based on the strength of the US health care system's ability to grow revenue, we must work directly with the health care system to control cost and manage revenue to control the growth of per capita spending.

IV. Description of Work to Date:

Update on key deliverables

1. Detailed list of design elements that are presently being used by the teams, and areas of importance that are not being used (case studies are being put on the wiki)
2. Defining the next step for the prototypes sites and our TA work (see section on Tests)
3. A significant start on operational definitions (work in progress)
4. Agenda for June Seminar (see Appendix)
5. At least one case study that supports design elements (see wiki)
6. Public wiki that shares knowledge about the Triple Aim (http://ihitripleaim.wikispaces.com/)
7. Define what we are missing:
   - Energy and will
   - Public Health involvement
   - Economist

V. Results of the 90-Day Scan:

What have learned so far during this Collaborative?

1 The teams do not need much help with choosing design elements or a population to work with. They did a great job in St Louis and have continued to focus on their populations.

2. We do not need any technical breakthrough for the teams to do work on the Triple Aim. We have adequate knowledge to improve the health of the populations. The concept of the Triple Aim seems to be an extremely attractive framework around which teams can organize both in the US and Europe.

3. Triple aim measures are new to most of the teams. Overall they are very early in their thinking about what the Triple Aim would look like for them. Their pilots are therefore generally not very large or aggressive.

4. We are just beginning to understand that working on the health of the population will not impact the per capita health care cost in the long run for the total population of a community. What this means is that the health care system has the ability to constantly generate new revenue streams. So no matter how much we improve basic care, chronic care, care coordination, etc., the per capita cost of health care as seen at a regional level will not be significantly improved until we control supply driven health care revenue streams. All of the teams are working on improving the health of the population and through that they are hoping to manage the cost of health care. This strategy may work for a time for a small-defined population because at a region level the health care system has many means to grow revenue that could adjust for lost revenue from a small population. However, some of the teams have not tackled controlling inappropriate revenue growth (supply side) of the health care system. Until they tackle that, they will not be able to impact per capita cost for their entire region.

5. The pilot work of Jonkoping is far advanced over the US teams. The work on the Triple Aim is natural to their thinking and much more difficult for the US teams.

6. Making choices based on what will produce the best outcome for a population is a new concept for some of the US teams.

7. The pilots are very good at identifying changes to improve health care. Understandably, there is less work by teams on making changes that will improve the health of the population through non-health-care-controlled interventions. One of our teams explained to me that they found in recent conversations that the health department was overwhelmed and under-resourced to be much of a partner for the Triple Aim. This is just one example and not necessarily representative of the whole, but to be successful teams will need to reach out to other agencies for partnership to improve the health of the population.

8. There is significant opportunity for improvement in execution. Putting together clear aims, measures, and change ideas has been difficult for many of the teams. However, they have responded well to coaching.

9. Some organizations are developing a business model around the Triple Aim. Their goal is to attract employers to their health care system by being a high-value organization that provides a lower cost for the care of a population while at the same time providing high quality. Their plan is to manage the growth of health care production and develop a strong base in improving the health of people that they care for. At least one of these organizations can already claim that the cost of their care is 26% lower than that of competitors for populations that they care for.

Characteristics of sites that should be working with IHI on the Triple Aim
(This section is organized into six major themes with bullet points under them)

1. STRATEGY AND VISION

- Has an executive team that understands that the Triple Aim is, or will be, strategic for their organization, and is prepared to make long-term investments and commitments to achieve the three aims;
  Note: It does not have to be the complete strategic focus for today, but it must be strategic for them in the next five years.

- Can clearly define the population that they are caring for now, and has a vision for the populations they hope to impact over the next five to ten years.

2. LEADERSHIP

- Identifies a top executive to oversee the work that the team will be doing with IHI. The named executive, along with the senior team, should be reviewing the team's progress on a regular basis.

- Seeks to identify and address inequalities and disparities in the care that is provided and the health outcomes of the population they serve.

3. ACCOUNTABILITY

- Can translate strategy into outcomes and has robust internal mechanisms to ensure planning, monitoring, and delivery mechanisms.

- Uses data and information to identify and prioritize areas for action, and track achievements.

4. PARTNERSHIP and External relations

- Are outward -looking and act as the Macro Integrator – enabling them to:
  - Obtain the entire range of services needed for a population.
  - Organize the range of services needed.
  - Influence those providing care in different settings.
  - Diagram the entire system as a single organized system.
  - Identify differences from what exists now.

- Seeks partnerships and relationships in order to deliver care, achieve health gain, and avoid duplication of effort, aiming to work as part of a community by actively working to develop partnerships with other groups such as social agencies; local government; and education, civic and religious organizations to improve the health of the community.

5. FOCUS ON RESULTS, People

- Works with the staff who provide care and develops clinical leaders to design care.

- Seeks the views of those they serve, develops a mandate for the decisions they make, and works as advocates for their customers.

6. FOCUS ON RESULTS, Finance

- Has a detailed view of their financial performance and has some (or is developing some) mechanisms for evaluating and planning on the basis of per capita cost and value for money.
  Note: Since per capita health care cost and the health of the population are not normal measures for US health care providers, some sites will have to think about new ways to collect data.

- Implements practice that has strong evidence behind it, and stops practice that does not have evidence to support it.

There is a questionnaire in Appendix C that would help evaluate any new teams that we might want to join us.

Tests to help support the future direction of the Triple Aim

Test 1

To accomplish the Triple Aim, each team will need to improve their system of basic/primary care. They need to answer the question: How do 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, each team 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.

The success of this test will be measured by decreasing emergency room visits and unscheduled hospitalizations for the population that they are working with. These will be two separate measures: unscheduled hospitalizations and ER visits.

Tests 2 and 3 Introduction

There is real promise in making an individual the driver/catalyst for change for the Triple Aim. The concept of working with the patient to learn for the population is an important concept that has not been used to the degree that we think possible. We must learn how to optimize the assets and motivators the individual brings to the conversation. It is their health journey and we must work with them to make it the best it can be. The patient and family can be the drivers for both cost and health outcome.

For instance, one patient had a significantly sore left ankle. In the context of his life, this was a significant impairment. The individual was active, played golf, and liked to walk to work. The patient consulted his primary care physician who could not find anything wrong and then referred the patient to an orthopedic doctor. The primary care doctor outlined no plan other than a referral to an orthopedic doctor. The orthopedic doctor examined the patient, took X-rays, and found nothing significantly wrong and recommended referral to a rheumatologist. Neither physician had discussed with the patient other potentials treatment that he could do or tried to understand the context of his life. They did not even equip the patient with an ability to run simple tests on his own. The only thing each had attempted was to define the problem with a specific diagnosis.

The patient on his own decided to keep a graph of pain, activities, and interventions. Based on this, he learned what treatments worked: ice in the evening, heat in the morning, Advil in the evening, and walking on the right side of the road (slope of the road is the explanation for this).

The patient was not equipped by the health care system with a tool as simple as graphing what hurt and what helped the problem. The health care system failed to equip the patient with a plan for conducting his own test to advise his treatment plan. Lastly, there was no real care coordination. Each doctor simply passed the patient to the next doctor without any real communication between them or coordinated plan with the patient.

Test 2

This test focuses on equipping/enabling the citizens of their population to manage their own health better. We know of several approaches to this work. For instance, Vermont and England have used Professor Kate Lorig of Stanford University's Chronic Disease Self-Management Program (CDSMP). This is an approach in which patients are training others in the management of their chronic diseases. Bellin and Genesys Health Care systems are using a health-coaching model. The overall focus is the same: to equip citizens to manage their own health. They will need to deploy tools and assistance for self-care and self-management.

The success of this work will be measured by the percentage of citizens who have health goals in place. There are other measures that could be considered: the number of citizens who have received either health coaching or health training, percent decrease in all face-to-face visits, a confidence and readiness score that is used by Bellin, the percent improvement in the population reporting perceived health status as good or excellent, or the percent of the population that is classified as low risk on the basis of a health risk appraisal.

Test 3

We need to learn from studying individuals.
Every month each team will take five cases and analyze them from the individual and family's point of view. How could they have improved the health outcome, decreased the cost, and improved the patient's health care experience?

After they have done the case analysis, they put appropriate changes into their system that will improve the value for the patients and families. The success of this test will be measured by the number of changes that they put in place based on their case study.

Observations on what we need for the Triple Aim Future work

1. We need organizations that truly have the Triple Aim as strategic.

2. We need to describe nasty dynamics that contribute to a system has high cost and low quality, producing a low-value system compared to other parts of the developed world.
   High Cost

- Supply-driven demand
- New technologies that are expensive and have a limited impact on outcome
- No mechanism to control cost at the population level (no population budget)

Low Value

- Reliance on a physician-centric model of health care
- No real foreign competition to spur change (cf. Toyota and the auto industry)
- Little appreciation or use of system knowledge (maximize the components for the sake of the whole)

3. We need a set of policy recommendations. Some questions to consider around those policy recommendations would be the following:

- How should the delivery system be organized at a macro-level? (When and how should providers compete?) (payment)
- What governance arrangements/constitutions should providers have? (I'm trying to get here to the question of government vs. not-for-profit vs. for-profit providers.)
- What are the implications of the two questions above for physicians' (and other clinicians') role, identity, professional values, and how we shape these?
- 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?

VI. Open Questions:

1. How do we build will for working on per capita cost? Or another way to say this is: How do health systems get involved with controlling their cost to Consumer Price Index?

2. Preventive health care, better coordinated care, improved access, better primary care, and improved chronic care will all improve the health of the population and the health experience, but will that by itself over the long term decrease per capita cost? Or is the ability of the health care system to generate new revenue streams stronger than all those improvements?

3. If costs are taken out, who are the winners and losers and how do you deal with them?

4. What else do we need to support the work of the Triple Aim?

VII. Conclusion and Recommendations:

1. Attempt to run the proposed tests with present teams and future teams.

2. Expand the Collaborative to include more teams in each segment and consider adding segments. The present segments are public health, not-for-profit health care systems, community-based HMOs, states, community coalitions, safety net, and European health systems. Add an industry segment to the mix.

3. Work on policy to support the Triple Aim. Consider having an economic summit to inform policy.

4. Continue the work on a primary care system by actually partnering with several organizations to help them implement change.

5. Continue to build will for the Triple aim through all of the above plus using communication channels.

Bibliography

1. Purchasing Population Health Paying for Results, David A. Kindig

2. What Is a Health System? Why Should We Care? William C. Hsiao K.T. Li Professor of Economics and Health Policy Harvard School of Public Health August, 2003

VIII: Appendices:

Appendix A
Overview of the agenda for the June meeting (This agenda is based on the fact that there will be many different types of people in the audience.)

1. Introduction
2. Define the problems with our present health system.
3. Introduce the Triple Aim framework which includes Triple Aim, operational definitions, and design elements. (We could include short sessions during the course that might build out some of these elements.)
4. Attendees select a population that they want to focus on.
5. Write up a case that represents an individual from that population.
6. Apply the design elements to that individual's care, optimizing the Triple Aim particularly removing cost from this population. They need to select the elements that they feel will be most helpful.
7. Now scale this work up for a population.
8. Define the measures that will be needed.
9. Develop a plan for testing these elements.
10. Set goals for this work.
11. Sometime during this session, introduce elements of the execution model.

Appendix B
Draft of Economic Discussion Meeting at IHI

The purpose of this meeting is to gain a better understanding of the major economic forces that contribute to our present health care system in the US and what economic changes might be necessary to induce significant change for improvement in the US. These economic recommendations could be used to inform policy debate.

Questions that we would want them to consider

1. How should the delivery system be organized at a macro-level? When and how should providers compete? (payment)
2. What governance arrangements/constitutions should providers have? (I'm trying to get here to the question of government vs. NFP vs. for profit providers.)
3. What are the implications of the 2 questions above for physicians' (and other clinicians') role, identity, professional values and how we shape these?
4. What are the economic levers for impacting the health systems that we see around the world today?
5. What government regulations have the greatest potential to influence the health system?
6. What specifically do you think should be improved with the US health system from an economic standpoint?
7. What should we do to impact supply driven demand? How are incentives out of line currently?
8. How do we break monopoly pricing?

Potential Economists for this Summit

Bill Scanlon - He is on the MEDPAC committee that sets Medicare rates and also on the National Policy Forum which advises Congress on Health Care Policy.
Regina Hertzlinger (market driven, consumer oriented)
Marc Roberts
David Cutler
Alan Garber at Stanford (if Alain Enthoven can't do it)
Michael Porter
Uwe Reinhardt
Mark Hemingway
Allen Eindhoven
Mark Pauley (Wharton)
Karen Davis
David Blumenthal
Jennifer Dixon from King's Fund in UK
Derek Feeley, head civil servant in Scotland for health
Stephen Thornton from UK's health foundation
Phil Hassen Canada who is currently Chair of ISQUA
David Levy, who commissions care for the whole Montréal area
Cris Ham from Birmingham Uni in England
Alan Maynard, health economist from York, England
Richard Bohmer from HBS (doing great work in evolving professional roles)
Onora O'Neill at Newnham, Cambs, UK

Paul Coombes ex-McKinseyDirector, very wise, who's been working extensively with Royal Colleges back in UK and is now on the board of LBS

Appendix C
Interview Questions for sites that wish to work with IHI on the Triple Aim

Strategy and Vision

How are goals developed for the organization?

How are these goals shared with the staff, partners in care and users of services?

How are strategic goals translated into practice, team goals and individual objectives?

How are resources allocated and tracked?

Leadership

How are senior leaders working with departmental team leaders and clinicians in the organization?

How visible are senior leaders to staff and patients?

Accountability

Who is accountable for performance and delivery at clinical team level?

What information does the board/senior team receive and how are decisions and actions tracked?

Partnership and External relations

In what ways are senior leaders engaged in developing partnerships outside the organization and with those who provide care as part of the wider system?

Are patients and users involved in shaping services and how are they engaged with internal committees?

Focus on Results, People

How do employees learn about priorities for the organization?

How do employees learn about achievements and outcomes?

What mechanisms are available for staff to raise concerns?

Have any staff had their scope of practice changed in the past two years, extended or limited?

Focus on Results, Finance

How does the organization implement new ideas and new technologies?

How does the organization identify practice which does not have evidence to support implementation or practice.

General Interview Questions

Describe a project that achieved great results and why do you think it was so successful?

Describe a problem that involved a patient and what the organization did about it? .

Appendix D
Subjects that should be covered during the learning session in April

1. What have we 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. Measures