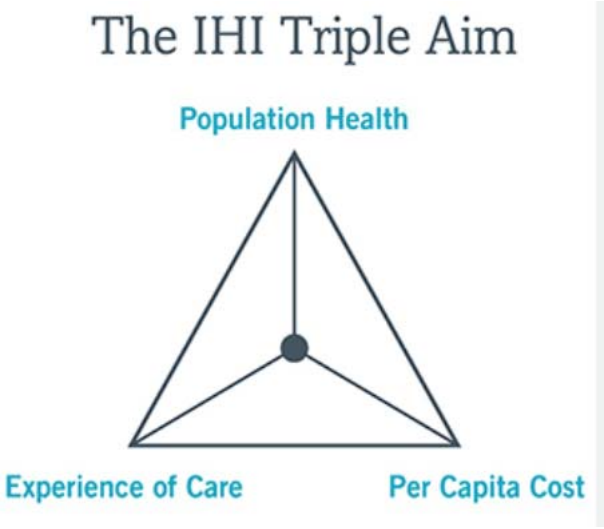
The Triple Aim Approach as a tool to reflect on health system reforms and integrated governance issues

Potential and pitfalls

Adalsteinn Brown, Director Institute of Health Policy, Management, and Evaluation and Dalla Lana Chair in Public Health Policy

What do we mean by Triple Aim?

The triple aim – developed by IHI – represents a substantial increase in health system goals over the Health Accord or even *Safer Healthcare Now!*



Why is the Triple Aim a Major Change

- Outcomes over appropriateness
- Population health over healthcare outcomes
- Experience of care equal to other dimensions
- Cost, outcomes, and experience not mutually exclusive

So what does it take to achieve the Triple Aim...

Adverse Events	 	Hospitals & Hospital Physicians
Readmissions	  	+ Community Physicians
Chronic Disease Mgmnt	   	+ Drugs
Population Health	    	+ Community Care
or…		
		Public health workers
…or all of the above		

My first experience with “all of the above”

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HealthcarePapers, 13(3) October 2013: 4-8.doi:10.12927/hcpap.2014.23690

Introduction

Public Health and Primary Care: Competition or Collaboration

Adalsteinn D. Brown, Ross Upshur and Terrence J. Sullivan

Abstract

In this commentary, the authors summarize and discuss some of the concerns presented in the papers herein, including issues of funding, skill sets and education. They present two key steps we could take across this country to ensure the long-term viability of public health within our healthcare system and ensure that public health and population goals are shared widely across our health systems.

What do we know about the Triple Aim and its Appeal

Triple aim type thinking works – but only to a limited extent – in institutional settings

ProvenCare[1]	forty verifiable behaviours for evidence-based cardiac surgery "hardwired" within the electronic health record	5% decrease in hospital charges
US Surgical Safety Checklist[2]	A two-minute tool that is designed to help operating room staff improve teamwork and ensure the consistent use of safety processes	$103,829 annual savings for hospitals with 4,000 non-cardiac operations
Simulation intervention in central venous catheter insertion [3]	mandatory simulation-based program on catheter insertion	Annual savings projected of approximately $700,000
Quality Improvement in Paediatric ICU[4]	1) Strict compliance on hand hygiene; 2) IHI VAP bundle; 3) compliance with guidelines on central-line catheters	Average adjusted costs were lower in ICU ($8,826) and in hospital ($12,136)
Michigan Keystone ICU Safety[5]	1) interventions to improve safety culture, teamwork, and communication and 2) interventions to improve compliance with evidence on central line-associated bloodstream infections	Savings for the average hospital was $1.1 million per year
Regional Surgical QI Program (Michigan)[6]	QI development program paid for by a private insurer	Net savings of $15 million (program cost $5 million)`

1 Casale et al. 2007; 2 Semel et al. 2010; 3 Cohen et al. 2010; 4 Harris et al. 2011; 5 Waters et al. 2011; 6 Share et al 2011

The opportunity for Triple Aim type results increases as the scope for action increases

Diabetes management program in Germany[1]	Primary care physicians enrol patients, educate and advise patients with regards to the management of their disease and use of the health care system	Net cost reduction o f$209.10 per enrollee
Quality and Outcomes Framework in UK[2]	Pay-for-performance incentive schemes; payment was determined by achievement of quality indicators related to 10 chronic conditions	Reduced hospital costs by approximately £130 million
Kaiser Permanente disease management program for diabetes and heart disease[3]	clinical guidelines, self management education, disease registries, risk stratification, proactive outreach, reminders, multidisciplinary care teams, and performance feedback to providers	Costs rose for each of the four conditions including 19 % for CAD patients
Kaiser Permanente Performance Improvement System[4]	Measurement, QI capacity development, support for improvement projects in 22 centres	Average savings of $2.36 for every $1 invested for a net return of $434,600 per centre
Intermountain QI efforts[5]	Measurement, capacity development, and central oversight and guidance for QI projects	Several examples of savings including $50 million through obstetric protocol redesign

1 Stock et al. 2010; 2 Dusheiko et al. 2011; 3 Fireman et al. 2004; 4 Schilling et al, 2010;

Things might get even more exciting with scope that includes public health… but is this more tyranny of the acute?

Community Health Worker Integration Into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home: A Bronx Tale

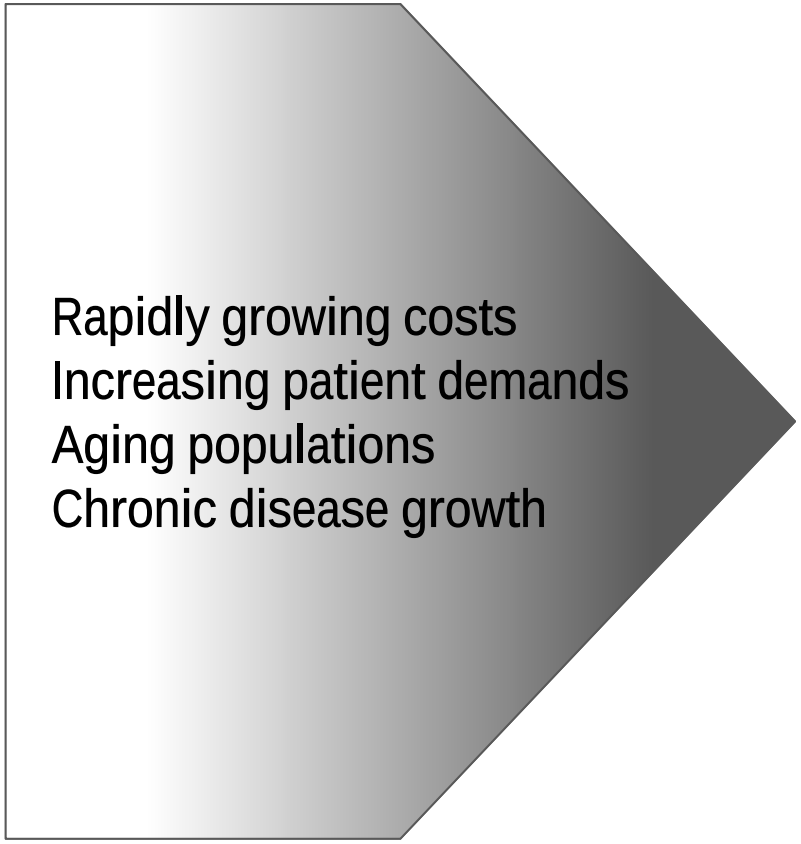
Findley, Sally PhD; Matos, Sergio BS; Hicks, April MSW; Chang, Ji MA; Reich, Douglas MD, MPH

Abstract

Community health workers are ideally suited to the care coordination niche within the patient-centered medical home (PCMH) team, but there are few case studies detailing how to accomplish this integration. This qualitative study documents how community health workers (CHWs) were integrated into a PCMH in South Bronx, New York. Results show that integration was linked to clear definition of their care coordination role within the care team, meticulous recruitment, training and supervision by a senior CHW, shared leadership of the care management team, and documented value for money. By helping the team understand patients' backgrounds, constraints, and preferences, they helped everyone genuinely focus on the patient.

How do policy-makers respond to linking cost, outcomes, and experience

Persisting policy problems[1] drive policy-makers towards greater integration and greater accountability across Canadian jurisdictions



Integration across sectors

- Regionalization
- LHINs
- Medical homes

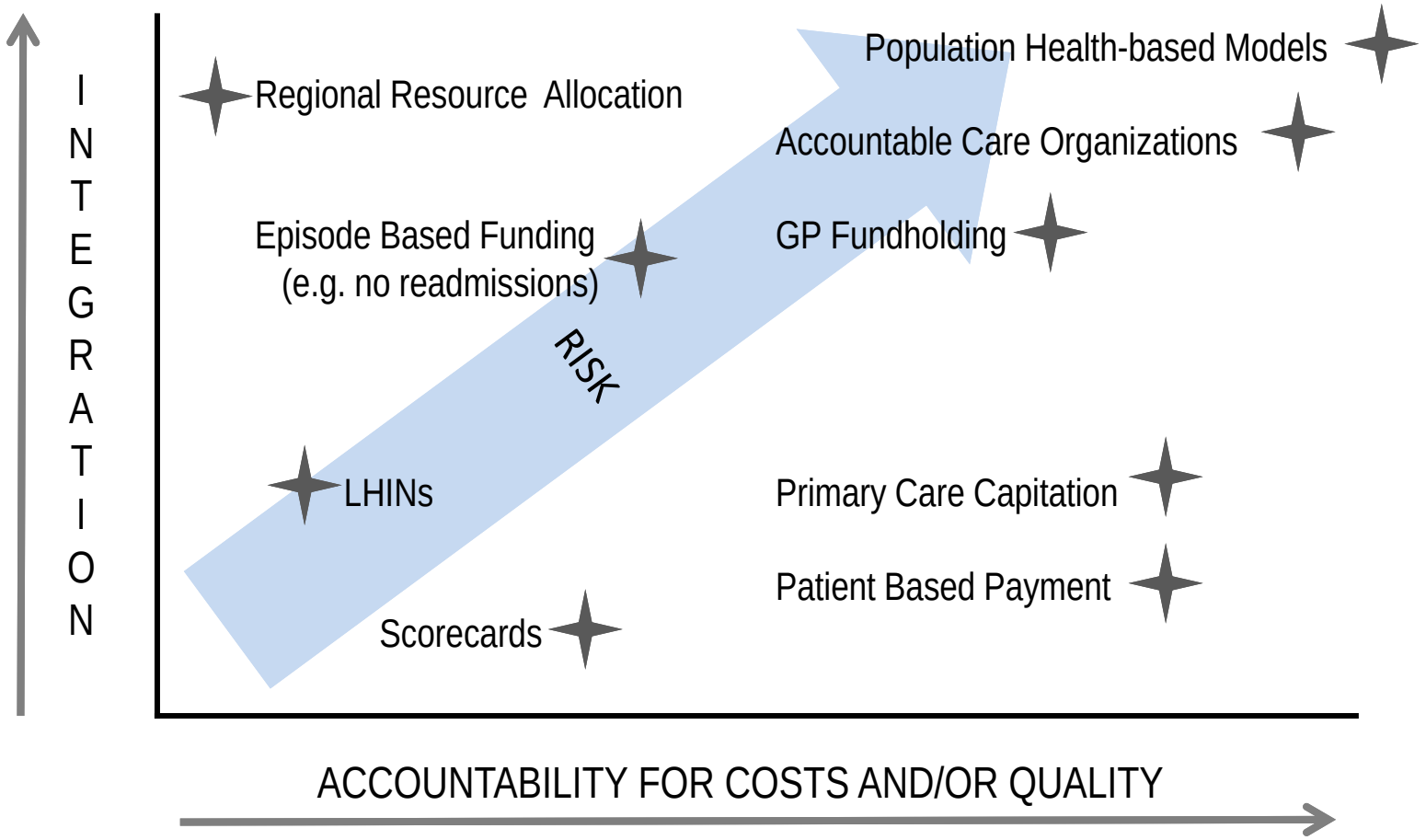
Provider accountability for cost and/or quality

- Activity-based funding
- CQI/TQM/LEAN
- Increased patient choice
- Scorecards and report cards
- Stewardship Competency

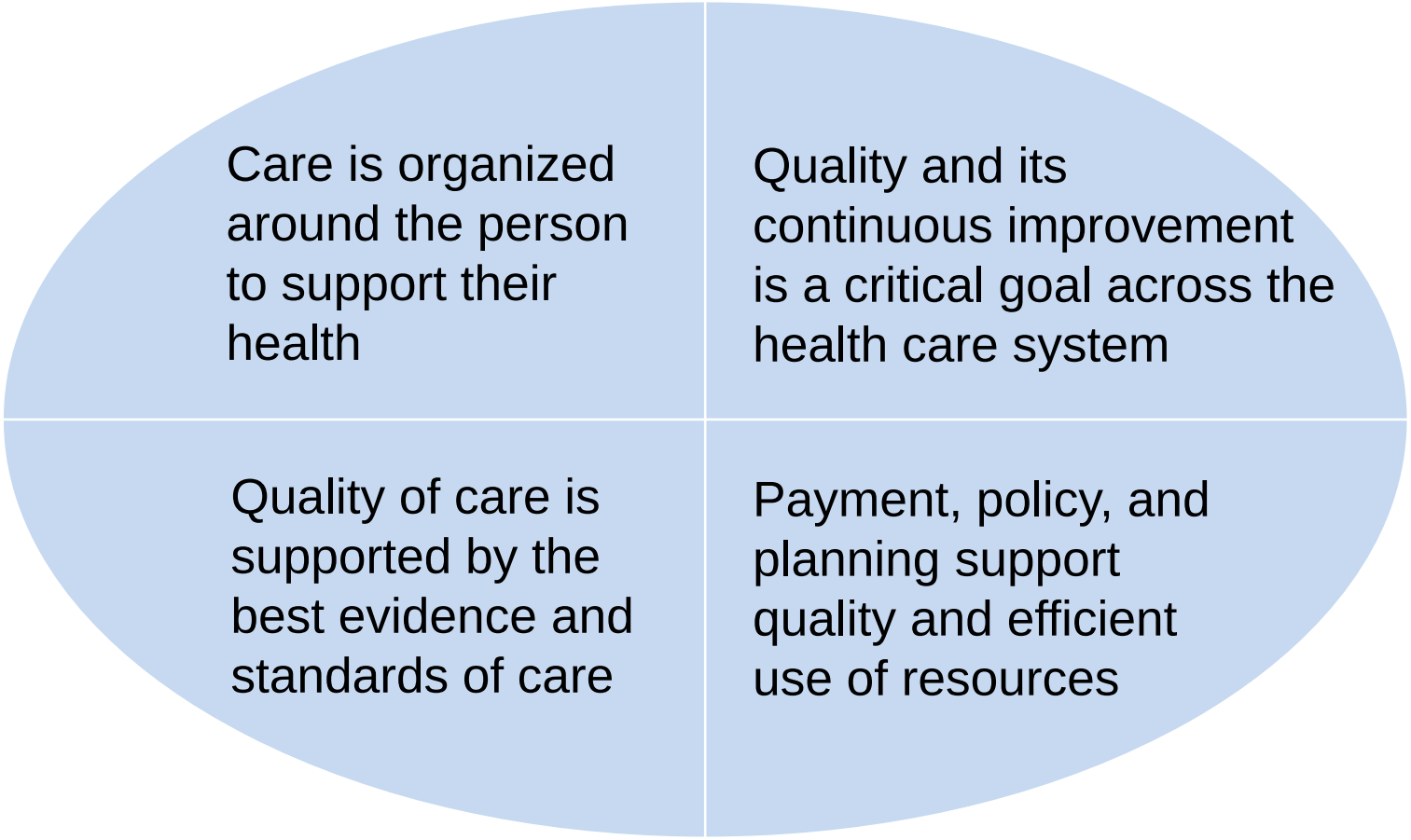
[1]Dixon A, Poteliakhoff E. Back to the Future: 10 Years of European Health Reforms. Health Economics, Policy and Law, 2012:7:s1-s10.

Policy makers are shifting risk for cost and quality for wider groups of services

This policy shift substantially changes the accountability landscape.



Starting with the passage of the Excellent Care for All Act, the Ontario government has launched a transformation strategy focused on four principles that mirror these broader trends



Is it working?
Selected studies from Ontario

- Kutty S, Ladak N, Muskat C, Paul J, Orchard M. The Excellent Care for All Act's quality improvement plans: Reflections on the first year. *Healthcare Quarterly,* 2012: doi:10.12927/hcq.2012.23156

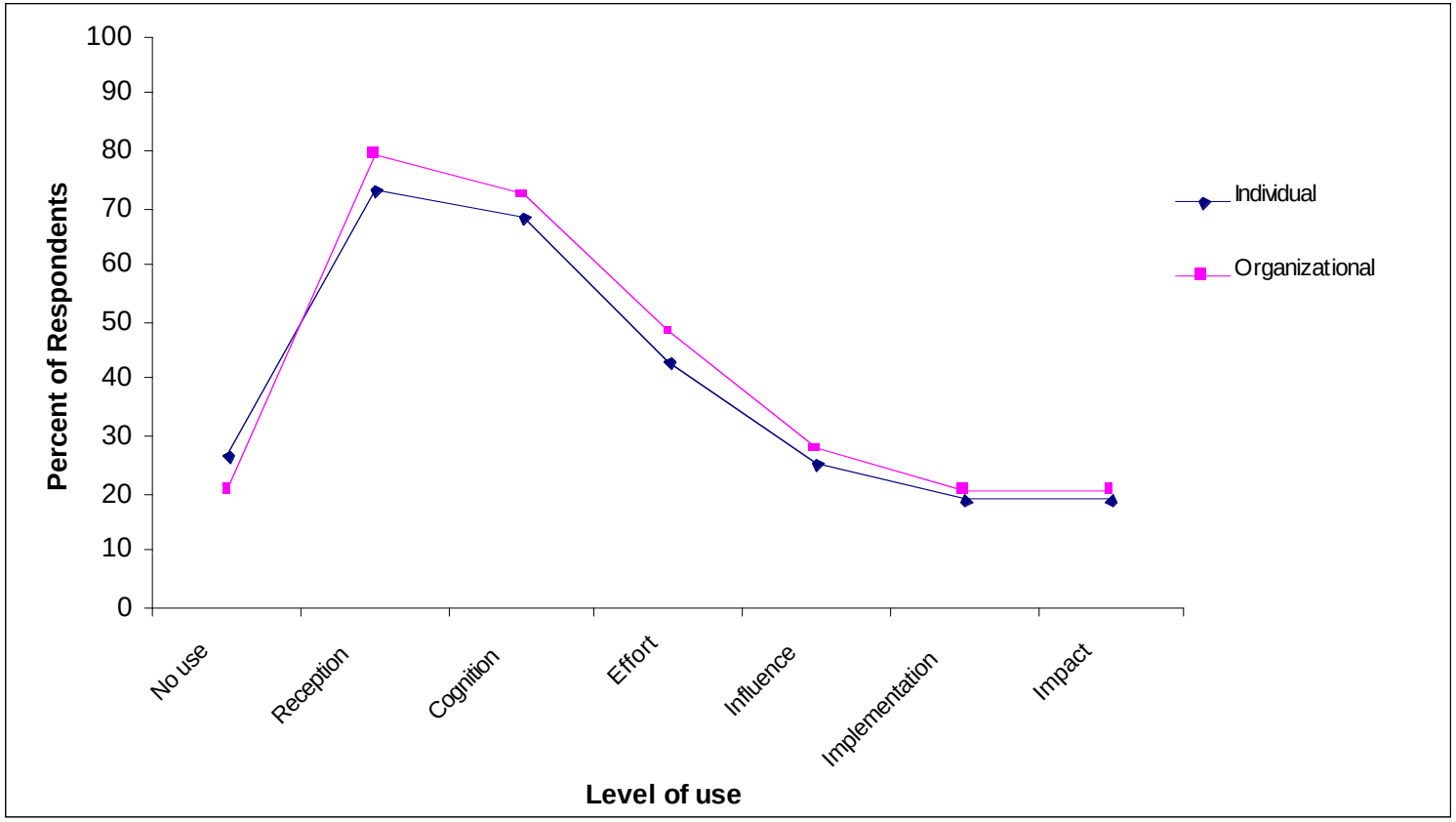
- Baker R, MacInstosh-Murray A. Governance for quality and patient safety. The impact of the Excellent Care for All Act. *Healthcare Quarterly, 2012:* doi:10.12927/hcq.2012.23161

- Sullivan T, Brown A. Inching towards accountability for quality: Early days for the Excellent Care for All Act. *Healthcare Management Forum*, 2014: doi:10.1016/j.hcmf.2014.03.010

So what are the options around roles and goals?

The articulation of clear and compelling goals in health system transformation will be critical

Ontario Hospitals' Use of Women's Health Performance Data[1]



[1] Siu E, Levinton C, Brown AD. The value of performance measurement in promoting improvements ... Healthcare Policy, 2009;5:52-67

The table stakes for transformation for will increase with an higher premium on data and capacity for improvement at a system level (including public health)

Current Model for Quality Transformation	New Elements for Next Generation
A public, specific statement of goals for improvement with a plan for reaching these goals	Cultural shift to goals over which no provider has control, merely influence
Public reporting of results with a clear link to improvement plans that become part of the strategy	Systematic measurement of equity and other goals and the collection of information to support this measurement
Strong physician & clinical leadership of improvement efforts aligned to improvement goals	Increased training in improvement as well as increased recognition that quality improvement is a portion of people's work that must be included. This training should start in medical school.
	Restructuring so that the connection across the patient journey must be much tighter to share costs and benefits across that journey

1 Brown AD. The Challenge of quality improvement at the system level: Whither CCO? Healthcare Quarterly, 17(SP) January 2015: 48-51.

Reforms that fail to include physicians will fail. What it means to be a physician will change

- The desire to link cost and quality will force changes in accountability
  - Accountability for competence will decline in relative importance while accountability for outcomes will increase in importance
  - Accountability for outcomes will increase team (cross-profession, cross-sector) work so that traditional measures of competence will decline in relative importance while leadership competencies will increase in importance
- These changes will create a profound challenge for regulators and leadership of the profession to create workable accountability systems
  - Picking important problems and fixing them[1] will require closer collaboration amongst regulators, associations, and government to reduce regulatory burden
  - Evaluation will shift away from typical screening type questions – *what proportion of competent doctors did we classify as incompetent?* – to a performance management framework – *how much did quality of care improve?*
  - The current collage of regulatory and performance management entities will either collaborate or will be replaced

[1]Sparrow M. The Regulatory Craft. Controlling Risks, Solving Problems, and Managing Compliance. Brookings Institution Press, Washington D.C., 2000

So what did we think would work...

The first is to start from the beginning. All healthcare professionals should see the public or population health perspective as part of their skill set and receive training in it from day one of their education. Advanced training programs such as graduate degrees and post-graduate training should try to bridge the disciplines, not reinforce professional silos. The second is to ensure that the goals for our health and healthcare systems include public and population health measures. There are none of these right now in Canada in any serious way. Focusing on access to care is an excellent way to ensure that we never shift toward population health. Targeting measures of health that are amenable to clinical and population health interventions is the best way to start real collaborations where both perspectives can contribute. Perhaps the first key step in linking public and population health to the rest of our health system is to have measures that reflect improvements in health, a goal that would bring the entire system to public health's doorstep.

Thank-you

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