

LOCAL HEALTH CARE REFORM IN OUR REGION: WHAT'S NEXT?

Triple Aim in a Region: A Talk by IHI's John Whittington, MD

On a spring evening at Cabrillo's Sesnon House, John Whittington, MD made the case for a regional approach to health care reform.

Pursuing Triple Aims

Dr. Whittington serves as lead faculty at the Institute for Healthcare Improvement (IHI) for an initiative called Triple Aim, which involves the simultaneous pursuit of three aims: improving patients' experience of care (as measured by the quality and safety of care, not just patient satisfaction), improving the health of populations, and reducing per capita health care costs.

Writing with his colleagues Don Berwick (IHI's founder and recently nominated as administrator of the federal Centers for Medicare and Medicaid Services) and Tom Nolan in the journal *Health Affairs* about Triple Aim's potential, Whittington noted that,

"Most recent efforts to improve the quality of health care have aimed to reduce defects in the care of patients at a single site of care. Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals."

Triple Aim is IHI's attempt to articulate these linked goals and support those who are interested in pursuing them with specific technical assistance and a peer learning network of like-minded organizations and communities. Santa Cruz County's Triple Aim initiative is one of 60

The **Health Improvement Partnership of Santa Cruz County** is a nonprofit coalition of public and private health care leaders dedicated to increasing access to health care in Santa Cruz County and to building stronger local health care systems.

The **Institute for Healthcare Improvement (IHI)** believes that patients deserve safe and effective health care, and has been working with health care providers and leaders throughout the world for 20 years to fulfill that promise. IHI's programs and activities are designed to enable committed individuals and organizations to innovate together, share knowledge, and collaborate on the difficult, rewarding work of improving health care.



"We are in this together,
collectively."

worldwide (40 of which are in the United States). The “ticket to admission” to the select Triple Aim community, Dr. Whittington noted, is to have done Triple Aim work before being invited to join — whether it falls under the Triple Aim name or not. One of the new converts to the Triple Aim approach is the Department of Defense, which is not only deeply engaged in the Triple Aim approach, but also added a fourth aim: the readiness of troops.

The Triple Aim Paradox

The simultaneous pursuit of the three Triple Aim goals is important; the idea is undermined if communities or entities like the Department of Defense concentrate on just one of the aims, at the expense of the other two. Yet market and other forces constantly pressure organizations and communities away from the simultaneous approach that Dr. Whittington and his colleagues see as essential.

As the IHI team observed in their *Health Affairs* article,

“We face a paradox with respect to pursuit of the Triple Aim. From the viewpoint of the United States as a whole, it is essential; yet from the viewpoint of individual actors responding to current market forces, pursuing the three aims at once is not in their immediate self-interest.”

Achieving these aims simultaneously requires that some organization (or group of organizations) plays an “integrator” role, becoming an entity that “accepts responsibility for all three components of the Triple Aim for a specified population.”

Drivers of Low-Value Care

What are the specific factors that drive us away from high-value health care? Dr. Whittington identified several, noting that most are generally true for Western culture and have been borne out through IHI’s Triple Aim work not only in North America, but around the world.

A “more is better” culture. In one country after another, Dr. Whittington and his colleagues have witnessed the seductive nature of whatever is shiny and new. The latest gadgets, drugs, and techniques are assumed to yield better outcomes than those they replaced, but this is not always the case — especially when costs and outcomes are viewed on a societal level, across entire populations.

- **A supply-driven mentality in health care.** In health care, the idea that “if we build it, we will fill it” leads to an oversupply of capacity such as Intensive Care Unit or other hospital beds — beds that then must be filled.
- **A lack of cost-control mechanisms.** The United States is unique in lacking a real budget to control health care costs at the population level, with few incentives to control growth. In California, Dr. Whittington observed, “your Medicaid budget is impacting your education budget.”

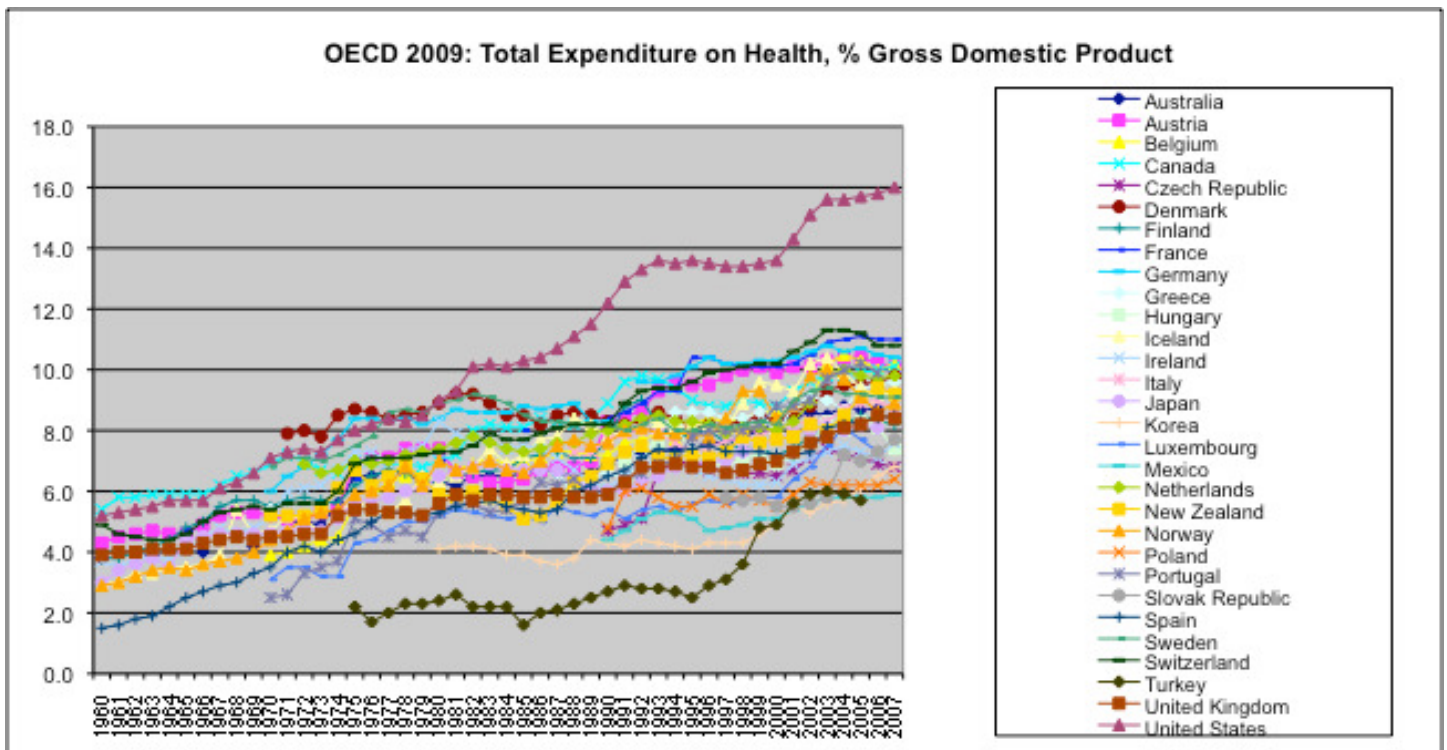
- **An over-reliance on doctors.** Dr. Whittington (a doctor himself) noted that this is not meant as a negative comment about doctors, but rather a comment on the limits of what can be accomplished in limited time in an exam room — and the many other factors outside an exam room that contribute to health.
- **Lack of appreciation for health care as a system.** The lack of a systems approach makes it difficult to see the costs of how we currently approach health care problems — and also obscures the potential benefits of doing things differently.

Health Care Expenditures: It's Our Money!

When we look at health care expenditures as a percentage of Gross Domestic Product (GDP), Dr. Whittington noted, the United States has the dubious distinction of being first, as shown on the graph below.

Even more important than costs, though, is what we get in return for these expenditures. Even if we make the assumption that health experiences and outcomes are similar, other countries are receiving twice the value for their expenditures.

Delving deeper into some of the nuances of the costs and expenditures, Dr. Whittington showed a chart comparing standardized mortality rates versus hospital reimbursement rates — concluding that there was no correlation between costs and health outcomes. He also



shared data from the *Dartmouth Atlas* comparing price-adjusted per capita Medicare spending in Hospital Referral Regions (HRRs) across the United States, which vary tremendously. Again, Dr. Whittington said, "it would be great if we could overlay Medicare spending with improvements in health and health care and say that it maps out — but it doesn't."

“Common Pool” Resources

These expenditures, Dr. Whittington said, are not just an abstract number over which we have no control or say. "It's our money!" he said, and we should be looking carefully at how it is spent in our communities. That's where the regional approach really makes a difference, because it stimulates us to think of health care — and what we spend on it — as a common resource. Like the economic parable of the Tragedy of the Commons (in which an individual's self-interest is served by adding one more sheep to a crowded pasture, but the common good of sufficient grazing land is undermined and eventually sabotaged if everyone acts this way), a common pool resource requires a different level of problem-solving and small individual sacrifices for a greater common good. Examples abound — from abalone fishing to sharing dwindling underground water supplies.

If health care premiums continue to go up, one immediate effect is the erosion of wage increases. Using a set of assumptions about income, health insurance premiums, and cost-sharing between an employer and employee, Dr. Whittington showed how an expected 3% increase in salary immediately becomes a 2.3% increase to offset the higher cost of the health care benefit the company continues to provide. Comparing employer and employee contributions and premiums in 1999 and 2009, Dr. Whittington concluded that a wage and benefits increase of 37% during this decade would have competed with a 131% increase in premiums — translating into lower wages in employees' paychecks.



Governing the Commons

Quoting the ideas of Elinor Ostrom (who won a Nobel Prize in economics in 2009 and whose thinking has been influential at IHI), Dr. Whittington noted her innovative work documenting how institutions — and particularly local organizations — can craft solutions to problems that elude the usual suspects (private or individual entities, and governments).

For those interested in learning more about her work, Dr. Whittington recommended her book, *Governing the Commons: The Evolution of institutions for Collective Action*. In it, she defines “common pool resources” as “a natural or man-made resource system that is sufficiently large as to make it costly (but not impossible) to exclude potential beneficiaries from obtaining benefits from its use.”

Coupling this idea with the flow of health care dollars and the geographic boundaries of a region is one way to move towards higher-value health care. In Bloomington, Illinois, where Dr. Whittington lives and works, hospitals are being built one after the other. “I don’t remember authorizing that,” Dr. Whittington said. “I never said we need more.” Yet business imperatives and opportunities have driven that growth — rather than people thinking through what they really need within their region.



“Common pool resources are a natural or man-made resource system that is sufficiently large as to make it costly (but not impossible) to exclude potential beneficiaries from obtaining benefits from its use.”

Triple Aim and the Potential of Regional Approaches

This is where Triple Aim comes in: creating specific goals and plans for per capital spending. In IHI’s view, it’s critical to keep spending growth level with inflation (not higher). But this inevitably means shifting resources and making hard decisions — such as closing hospital beds. “We are in this together, collectively,” Dr. Whittington said, reiterating his point: “It’s our money.” He continued, “We can’t afford to think about it as just a business opportunity, or a community, or an individual.”

The rationale for a regional focus and approach is strong and compelling, Dr. Whittington concluded. Key questions to ask include how we define our region, who the major players are, gauging how the region performs in terms of Triple Aim measures, what our goals might be, and what our capital investments (“our money”) say about where the region is heading.

All the components needed to construct a health system are already in a region, waiting to be tapped. Through this lens, common values are more likely to emerge — along with solutions that take local knowledge and context into account. A regional approach also creates platforms for dialogue that might not surface otherwise, and for highlighting the role of other systems and players on health outcomes. As an example, Dr. Whittington noted that his daughter is a school librarian in a lower-middle class elementary school in suburban Chicago. Commenting on the largely unheralded role that the education system plays in influencing health outcomes, Dr. Whittington said, “She will produce more health in her lifetime than I will in mine as a family physician.”

Outside of the United States, regional approaches are common; within our borders, they are rare. Even out of the 40 U.S. Triple Aim sites, Dr. Whittington estimated, fewer than a dozen have adopted a regional approach — and among these, he considers Santa Cruz County to be ahead of the game. “I tell your story,” he told an appreciative audience of Santa Cruz County leaders from health care and other sectors, convened by the Health Improvement Partnership of Santa Cruz County.

“You started working on Healthy Kids, and childhood obesity. You moved on to electronic medical records. Different things pull communities together, and now you're learning key principles of Triple Aim, extracted from other regions that have worked together to move forward. If you're smart, you don't think of this work as one project, one issue — but rather as a long-term thing, building social capital that is sustainable in a region. We at IHI think you illustrate these principles — but we also think you're at a point where you could step up and do more in the region.”