Leadership for the Next Millennium: Creativity, Innovation, and Quality

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Maureen Bisognano
President and CEO
IHI
Columbia, South Carolina
Richland County - 29203

Population Percentages

- White: 66.2%
- African American: 47.3%
- Hispanic/Latino: 14.1%
- Other: 27.9%
- Total: 83.8%

South Carolina: 4,625,364
Richland County: 384,504
29203: 42,459
Healthy Columbia
The Four Leadership Questions

• Do you know how good you are?
• Do you know where you stand relative to the best?
• Do you know where the variation exists?
• Do you know the rate of improvement over time?
# How does Canada perform?

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and timeliness</td>
<td>C+</td>
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<tr>
<td>Equity</td>
<td>B</td>
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<tr>
<td>Safety</td>
<td>B</td>
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<tr>
<td>Effectiveness</td>
<td>B+</td>
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<tr>
<td>Capacity</td>
<td>B (incomplete basis for evaluation)</td>
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<tr>
<td>Patient-centeredness</td>
<td>B</td>
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Strengths

- Cancer care
- Diabetes care
- Cardiac and stroke care
- Costs
Cancer Care

Potential years of life lost, cancer, 1992-2005

Source: OECD, 2008

Breast Cancer Five-Year Relative Survival Rate, 2002–2007 (or nearest period)

Source: OECD Health Care Quality Indicators Data 2009.
Diabetes Lower Extremity Amputation Rates per 100,000 Population Age 15 and Older, 2007

Source: OECD Health Care Quality Indicators Data 2009.

* 2006.
** 2005.
*** Among countries shown.
Spending on Health

Total expenditure on health as a percentage of GDP, 1992-2006

Source: OECD, 2008

Strengths and Opportunities

Opportunities for Improvement

• Use of electronic records
• Some areas of preventions
• Performance gaps across the country between populations and geographical areas

➤ “We’re the best at everything; just not everywhere.”
Primary care physicians' use of electronic patient medical records, survey, 2006

Mortality from cancer, 2005

The Challenges

• In the US, we spend over $2.7 trillion per year on health care
• Over 75% is spend on chronic disease management
• And all of our chronic diseases are getting worse
The Challenges

- In the North America and across Europe, the same 75% of health care budgets are going to chronic disease care.

- Diabetes, cardiac disease, and obesity are expected to increase by 50% by 2035.

- The “burden of the illness” in these diseases is 24/7 and requires a new way to look at the “burden of the treatment,” including designs and costs.
Obesity Trends* Among U.S. Adults
BRFSS, 1985
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

Source: Behavioral Risk Factor Surveillance System, CDC.
Obesity Trends* Among U.S. Adults
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

Source: Behavioral Risk Factor Surveillance System, CDC.
Obesity Trends* Among U.S. Adults
BRFSS, 2000

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

Source: Behavioral Risk Factor Surveillance System, CDC.
Obesity Trends* Among U.S. Adults
BRFSS, 2005
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2010
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

Source: Behavioral Risk Factor Surveillance System, CDC.
Not Just an American Problem

THE GLOBAL OBESITY PROBLEM

An obese adult is classified as having a Body Mass Index equal to or greater than 30.

SOURCE: World Health Organization, 2006
Prevalence estimates of diabetes, 2025

SOURCE: DIABETES ATLAS THIRD EDITION, © INTERNATIONAL DIABETES FEDERATION, 2006
The top 1% of spenders accounts for 21.8% of the costs

The next 4% account for 28.2% of the costs

The bottom 50% account for just 3% of the costs

**Where Are We?**

- **Clinical Model**
  - Episodic Care → Coordinated Care → Population Directed Care

- **Business Model**
  - Fee for Service → Bundled Payment/Capitation → Disruptive Innovation?

- **Infrastructure**
  - Segmented → Integrated → Cloud

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**Technical Leadership:**
- Problem solving through expertise

**Adaptive Leadership:**
- New beliefs & behaviors
- New relationships
- New customers

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Adapted from *The Second Curve*, Ian Morrison 1996
The IHI Triple Aim

Experience of Care

Per Capita Cost

Health of a Population
Looking Back

• Great progress “within the walls”
  – Safety
  – Access
  – Some new models and processes
  – Hearing the patient’s voice
  – Beginnings of electronic records and new technology
Looking Forward

• Where we need to go…
  – At the patient level
  – At the organizational level
  – In the community
At the Patient Level

• Move from “What’s the matter?” to “What matters to you?”*

• The patient is not the problem (Muir Gray)

• “Minimally Disruptive Medicine” (Victor Montori)**
  — Having conversations with the patient, understanding patients (not just their diseases) and their lives

• Patient goal setting

Patient Goal Setting

• “…focus on a patient’s individual health goals within or across a variety of dimensions (e.g., symptoms; physical functional status, including mobility; and social and role functions) and determine how well these goals are being met.”

—David Reuben, MD & Mary Tinetti MD, *NEJM*, 3/1/12

Compliance with Multi-disciplinary Rounds and Daily Goals

74%

93%
ICU Mortality Reduction

24% improvement

18.2%
13.9%
Newborn Integrated Care

Mount Sinai Hospital in Toronto revolutionizes care for their tiniest patients

A new family integrated care initiative engages parents to:

- Commit to spending a minimum of eight hours at the Hospital each day
- Receive coaching from the inter-professional multidisciplinary team to build their confidence on providing basic care for their baby such as feeding, bathing, changing diapers and how to hold their baby for as much skin-to-skin contact as possible
- Take the lead in care planning, chart their baby’s progress and present at rounds each morning to physicians and other clinical staff
- Have the emotional support of specially trained Parent Buddies who have had babies of their own in the NICU. They understand the obstacles parents face and are able to share their unique experiences.

A Patient Goal-Setting Example from Saskatchewan

- Dr. Susan Shaw is the Chair of the Health Quality Council, and Department Head, Adult Critical Care, Saskatoon Health Region. She is Physician Co-lead for the Saskatchewan Surgical Initiative and an Assistant Professor with the College of Medicine's Department of Anesthesiology, Perioperative Medicine and Pain Management at the University of Saskatchewan.
Patient Goal-Setting

• It’s Dr. Shaw’s routine to create a list of daily goals for each patient as she completes morning rounds.

  ➢ Every morning the care team meets at the bedside of each patient. Often the patient’s family joins too.
  ➢ Each team member presents his or her assessment, then together they create a plan for the day.
  ➢ By the end of the group discussion, they have a list of daily goals for the next 24-hour time frame on the whiteboard next to each patient’s bed.
  ➢ These goals solidify and help communicate the plan, making sure they all know what each team member needs to contribute that day.
Patient Goal-Setting

- One morning, during rounds in the ICU, a patient’s daughter jumped up with excitement and said, “Look at what Mom wrote for you!”

- She showed a piece of paper on a clipboard, with two goals written in somewhat shaky writing.
Patient Goal-Setting

- “Heal this broken body”
- “Cut grass”
Patient Goal-Setting

• Daily goals shouldn’t only focus on:
  – a negative fluid balance
  – a specific level of wakefulness
  – Follow-up with a pathology report
  – moving to the next step on the ICU mobility protocol, etc.

• These goals are important. They provide direction for the ICU nurses and therapists. But they aren’t inspirational or motivational. They are simply small steps that must be taken to get us to what really matters: the goals set by our patients.
Medical Legal Partnership: Transforming Healthcare and Law

Prevailing Model

• Service is crisis-driven
• Individuals are responsible for seeking legal assistance
• Primary pursuit is justice
• Service is preventive, focuses on early identification of and response to legal needs
• Healthcare team works with patients to identify legal needs and makes referrals for assistance
• Aims include improved health and well-being

Health Care

• Adverse social conditions affect patient health but are difficult to address
• Healthcare team refers patients to social worker/case manager for limited assistance
• Advocacy skills are valued, taught and deployed inconsistently
• Adverse social conditions with legal remedies are identified and addressed as part of care
• Healthcare, social work, and legal teams work together to address legal needs, improve health and change systems
• Advocacy skills are prioritized as part of the standard of care

Source: Barry Zuckerman, MD, BU School of Medicine, Boston Medical Center
For more information: www.medical-legalpartnership.org
At the Patient Level

- Move from “What’s the matter?” to “What matters to you?”*

- Build a way to assess the assets the patient and family bring

- Use daily goals and multi-professional rounds with patients in hospitals

- Use longer-term goals for well patients and those with chronic disease

At the Organizational Level

- New ways to work
- New ways to build the assets and skills of all who work in your organizations
- New ways to care
“Nuka” – Alaskan word for strong, giant structures and living things.

— Also the name for the health care model that transformed the system from health care transactions for patients to a healthy system with the population
So, Our Choice to Redesign

- The Alaska Native people were given control of the system and we chose to assume the responsibility to rethink our own health care
  - Total Redesign - Change everything
  - Keep the best of Modern Medicine
  - Change the basis to Alaska Native Values and Wisdom of the Elders
  - Put the Customer-Owner in control at all levels
  - Relationship optimization at core of services and mgt
Family Wellness Warriors Initiative (Relationships)

Goal: To end Domestic Violence Child Sexual Abuse and Child Neglect in this generation

Use of story and relationships to break the cycles of violence and neglect

Understand violence and neglect as symptoms of a family system with broken relationships – and heal the individual by healing the family system

Objectives: Call out the Warriors, Methods to counter and break the silence, Restructure systems, Establish safe adults and environments, Enhance existing resources and develop collaborations
Some Programs (Relationships)

- **Elder Program**
  - Healthy Elders through supportive gathering, activities, sharing, caring - relationships

- **Pathway Home**
  - Recovering youth through development of community, healthy relationships, personal and group responsibility

- **RAISE**
  - Youth internships emphasizing team, group, learning, responsibility, skills – within SCF Nuka System of Care (relationships)

- **Dena-A-Coy**
  - Residential treatment for pregnant women to return to healthy relationship with self, family, pregnancy, newborn infant.
Some Programs (Relationships)

- **Nutaqsiivik**
  - Two year partnering in intensive personal relationship between SCF staff and new mothers with infants

- **Quyana Clubhouse**
  - Long term personal relationships with individuals with limited cognitive capabilities and mental health challenges to support healthy living

- **Primary Care**
  - Complete rethinking of what our roles are – everyone – in the integrated care team environment where trusting, accountable, long-term, personal relationships are the core service delivered – with full same-day access – and the whole person and family are supported.
Why listen to our story

- Evidenced-based generational change reducing family violence
- 50% drop in Urgent Care and ER utilization
- 53% drop in Hospital Admissions
- 65% drop in specialist utilization
- 20% drop in primary care utilization
- 75-90%ile on most HEDIS outcomes and quality
- Childhood immunization rate of 93%
- Over 50% of Diabetics with HbA1c below 7%
- Employee Turnover rate less than 12% annualized (very low)
- Customer and staff overall satisfaction over 90%
- In an urban Alaska Native community with huge challenges
- Sustained for over a decade and continually improving
- Very long list of external recognitions – Baldrige Award now
Per Capita Expenditures

Cumulative Per Capita Expenditures
Relative % Change with 2004 as Baseline

Relative % change from baseline

2004  2005  2006  2007  2008  2009

-10   -5    0     5     10    15    20    25    30    35    40    45

Better

SCF Cumulative Primary Care
SCF Cumulative Hospital Services
MGMA Cumulative Increase (Multi Specialty Cost)
Organizations Learning from Patients

The Old Way

• Ryhov Hospital in Jönköping had traditional hemodialysis and peritoneal dialysis center.
• But in 2005, a patient, Christian, asked about doing it himself.
The New Way

• Christian taught a 73-yr-old woman how to do it...

• ...and they started to teach others how to do it.
The New Way

• Now they aim to have 75% of patients to be on self-dialysis
• They currently have 60% of patients
Lessons to Date

• From Christian (patient):
  — “I have a new definition of health.”
  — “I want to live a full life. I have more energy and am complete.”
  — “I learned and I taught the person next to me, and next to her. The oldest patient on self-dialysis is 83 years old.”
  — “Of course the care is safer in my hands.”
Lessons to Date

- From Anette (nurse leader):
  - Surprised at design differences between patients, family, and staff
  - Managing at 1/2 – 1/3 less cost per patient
  - Evidence of better outcomes, lower costs, far fewer complications and infections
  - “We brought in the county’s employment, helped the patients make or update the CVs, and trained them for a new career.”
Update

- Now calculated costs at 50% of costs in other hemo-dialysis units

- Complications dramatically reduced and subsequent expensive care avoided

- Measuring success by “number of patients working”
Jonkoping Visit, October 2011

Leaders from York and Harrogate NHS Trusts
In 3 Years, Our Model of Care Will Be:

- We plan to initiate shared haemodialysis care in dialysis centres across Yorkshire and Humber.
- We will do this by –
  - Setting up a course to teach dialysis nurses how to support patient to learn aspects of their own dialysis.
  - Supporting willing patients to learn as much of their own dialysis as they wish to.

We believe that a culture of Sharing the care on Haemodialysis is the foundation for Self care on dialysis units.
PFCC

GO GUIDE 2.0
TRANSFORM CARE IN SIX STEPS
THE PATIENT AND FAMILY CENTERED CARE METHODOLOGY AND PRACTICE

Anthony M. DiGioia III, MD • Patricia L. Embree • Eve Shapiro
and a Cast of Thousands of PFCC Champions, Patients and Families
Dr. Anthony M. DiGioia III, orthopedic surgeon and developer of the patient- and family-centered care program for UPMC, in his office at Magee-Womens Hospital in Oakland.
Wellness Focus
Results

• Safe:
  – Mortality rate: 0%
  – Infection rates: 0.3% (0.2% for TKA and 0.7% for THA)
  – Zero dislocations
  – SCIP compliance: 98% for antibiotics within one hour of surgery
Results

• Effective:
  – 95% of patients discharged without handheld assistance directly to home (national rates: 23-29%)

  – 99% of patients reported that pain was not an impediment to physical therapy, including same-day-of-surgery physical therapy
Results

- **Patient-centered:**
  - Press-Ganey mean satisfaction score is 91.4% (99\textsuperscript{th} national percentile ranking) with 99.7% positive responses to “Would you refer family and/or friends?”

- **Efficient:**
  - Average length of stay:
    - 2.8 days for TKA (national average is 3.9 days)
    - 2.7 days for THA (national average is 5.0 days)
  - One MD able to perform 8 joint replacements before 2:00pm
Study Tour in Denmark
At the Organizational Level

- Explore the assets and skills in your staff, and redesign to optimize their expertise

- Redesign care *with* patients

- Seek out the best innovations and send a team to explore
In the Community

- Understand your community deeply…both its needs and its assets
- Look outside of the current system
- Create new connections
Health

The Robert Wood Johnson Foundation defines it this way:

“Health starts where we live, learn, and play.”
Determinants of Health

And the World Health Organization defines the social determinants of health as:

“The conditions in which people are born, grow, live, work, and age…including the health system.”
Determinants of health

- Environment
  - National economic strategy
- Education
- Agriculture and food
- Eating habits
- Recreational and culture
- Exercise
- Social network
- Sex and peaceful coexistence
- Social insurance
- Public assistance
- Health care
- Children's contact with adults
- Sleeping habits
- Health care
- Unemployment
- Alcohol
- Tobacco
- Social support
- Work environment
- Living situation
- Traffic
- Drugs

Age
Sex
Heredity

Courtesy of the Institute for Healthcare Improvement, April 2009
Malawi Progress

- Population ~13 million
- Maternal mortality: ~350/100,000 (USA <10/100,000)
- Neonatal Mortality: ~30/1000 (in the US ~4/1000)

3 Districts
- Aim: Reduce maternal and neonatal mortality by 30% in three Districts (pop 3 million) by February 2012.
- 5-year RCT to test health facility (QI), and community interventions (women’s groups)

Partners: Women and Children First, Inst Child Health UCL, IHI. Funders: The Health Foundation.
Focus of our Interventions

3 Delays model

• Delay in deciding to seek care
• Delay in reaching the facility
• Delay in receiving timely and appropriate care

Women Groups & Task Forces

QI intervention
Focus on Demand, Supply and Linkages

Referral & Access

Increasing Demand

Quality services
Malawi: Results Over 4 Years

Infrastructure for change
- Established new NGO – MaiKhanda
- Community structures: 650 Women’s groups
- Facility structures: 55 QI teams formed (13 hospitals, 42 health centers)
- Linkage structures: 707 safe motherhood task forces

RCT evaluation results show:
- 22% reduction in NMR for combined FI and CI intervention (no effect for either intervention alone)
- 16% reduction in perinatal mortality for CI alone, no effect of FI alone
- No reduction of MMR over secular trends
Columbia, South Carolina
Health Impact Pyramid

- **Socioeconomic Factors**
  - **Changing the Context**
    - To make individuals’ default decisions healthy
  - **Long-Lasting Protective Interventions**
  - **Clinical Interventions**
  - **Education & Counseling**

Source: Dr. Tom Frieden, Director of the Centers for Disease Control and Prevention
Neighborhoods, Obesity, and Diabetes — A Randomized Social Experiment

Jens Ludwig, Ph.D., Lisa Sanbonmatsu, Ph.D., Lisa Gennetian, Ph.D., Emma Adam, Ph.D., Greg J. Duncan, Ph.D., Lawrence F. Katz, Ph.D., Ronald C. Kessler, Ph.D., Jeffrey R. Kling, Ph.D., Stacy Tessler Lindau, M.D., Robert C. Whitaker, M.D., M.P.H., and Thomas W. McDade, Ph.D.

ABSTRACT

The question of whether neighborhood environment contributes directly to the development of obesity and diabetes remains unresolved. The study reported on here used data from a social experiment to assess the association of randomly assigned neighborhood conditions with obesity and diabetes.
In the Community

• Understand your patient segments, and the key drivers to their health

• Map your community assets (inside and outside health care)

• Move down the Health Impact Pyramid to include new designs and contexts
Key Messages

• Move from asking, “What’s the matter?” to “What matters to you?”

• Identify and build on the assets in your patients, in your organizations, in your communities

• Move from disease care to health care

• Focus on your own health and your family’s health
Moving to ‘A’

• A way to see the gaps and the potential (a pan-Canadian system of measurement? Dan Florizone)
• A capable system of improvement capability
• New ways to innovate to produce new models of care
• A pan-Canadian spread strategy
• Public voice and engagement
• Demonstrations of your commitment to equity and justice
Thank You! and Merci!

Maureen Bisognano
President and CEO
Institute for Healthcare Improvement

www.IHI.org
info@ihi.org
617-301-4800