New care models to capture the critical intelligence needed for sustainability

Learning from new care models here and abroad: making accountable care happen
The King's Fund, London, 3 October 2017

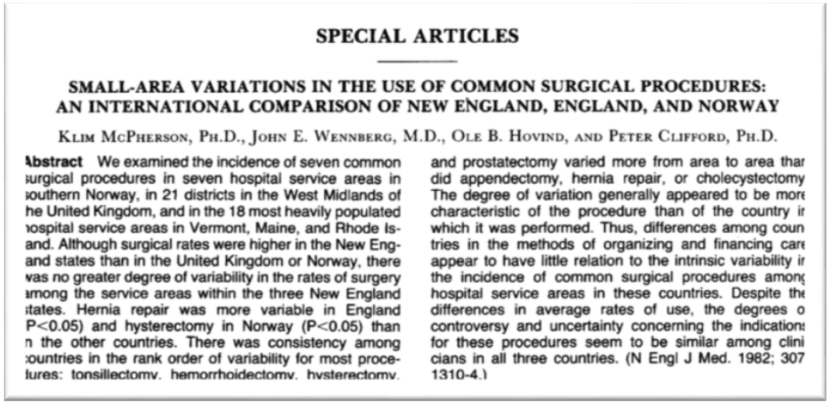
Professor Albert Mulley, MD, MPP
The Dartmouth Institute for Health Policy and Clinical Practice
Visiting Professor, UCL
Former International Visiting Fellow, The King's Fund

The King's Fund

THE Dartmouth INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Learning from Variation in NHS England and the United States

- Dartmouth has been engaged with the NHS for decades in a partnership in learning from variation
- In the US, new care models originated as responses to **unwarranted *and* warranted variation**…
  - **at the frontlines** with patients engaging in decisions and care management; and
  - **at the organisational level** with service providers assuming accountability for quality and costs
- The ***Five Year Forward View*** presented the opportunity for the NHS-Dartmouth partnership to…
  - pursue together the **strategic intent 'to learn from variation to deliver what is valued'**; and
  - achieve accountable care by leveraging **NHS advantages** to **iteratively test 'the sustainability hypothesis'**



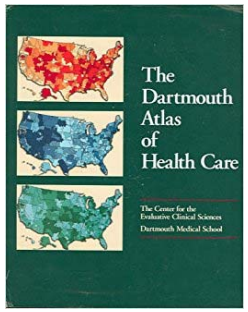
SPECIAL ARTICLES

SMALL-AREA VARIATIONS IN THE USE OF COMMON SURGICAL PROCEDURES: AN INTERNATIONAL COMPARISON OF NEW ENGLAND, ENGLAND, AND NORWAY

KLIM MCPHERSON, PH.D., JOHN E. WENNBERG, M.D., OLE B. HOVIND, AND PETER CLIFFORD, PH.D.

Abstract We examined the incidence of seven common surgical procedures in seven hospital service areas in southern Norway, in 21 districts in the West Midlands of the United Kingdom, and in the 18 most heavily populated hospital service areas in Vermont, Maine, and Rhode Island. Although surgical rates were higher in the New England states than in the United Kingdom or Norway, there was no greater degree of variability in the rates of surgery among the service areas within the three New England states. Hernia repair was more variable in England ($P<0.05$) and hysterectomy in Norway ($P<0.05$) than in the other countries. There was consistency among countries in the rank order of variability for most procedures: tonsillectomy, hemorrhoidectomy, hysterectomy, and prostatectomy varied more from area to area than did appendectomy, hernia repair, or cholecystectomy. The degree of variation generally appeared to be more characteristic of the procedure than of the country in which it was performed. Thus, differences among countries in the methods of organizing and financing care appear to have little relation to the intrinsic variability in the incidence of common surgical procedures among hospital service areas in these countries. Despite the differences in average rates of use, the degrees of controversy and uncertainty concerning the indications for these procedures seem to be similar among clinicians in all three countries. (N Engl J Med. 1982; 307 1310-4.)

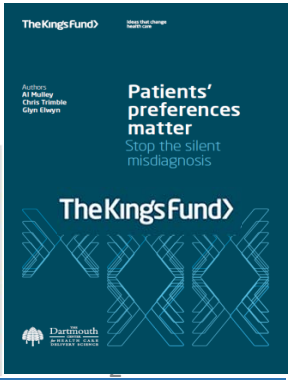
McPherson, Wennberg et al. N Engl J Med 1982



NICE RightCare NHS

The Health Foundation Inspiring Improvement

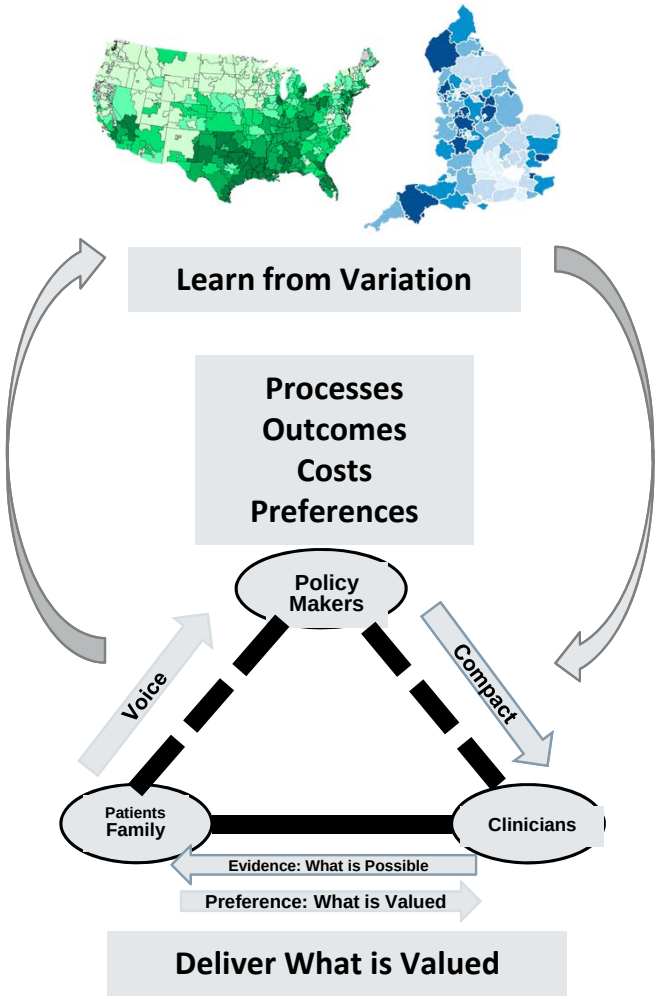
nuffieldtrust evidence for better health care



Mulley, Trimble, Elwyn, 2012

Pursuing a Common Strategic Intent

Learning from variation to deliver what is valued



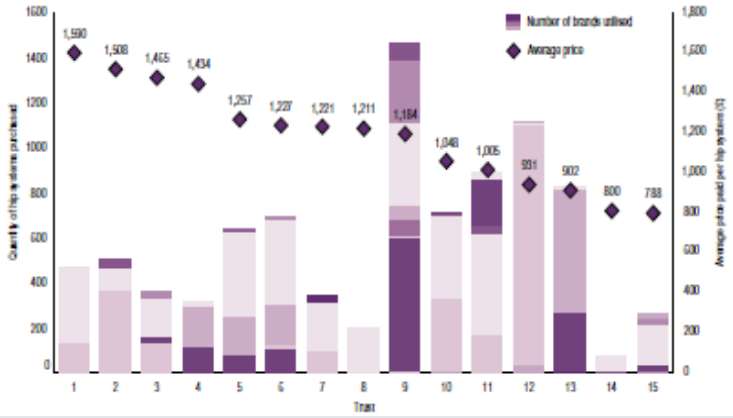
- We learn from ***variation in outcomes and costs*** by making visible the underlying ***variation in processes…***

- We learn from ***variation in practices*** by making visible the underlying ***variation in preferences…***

Learning from Variation in Joint Replacement across NHS England

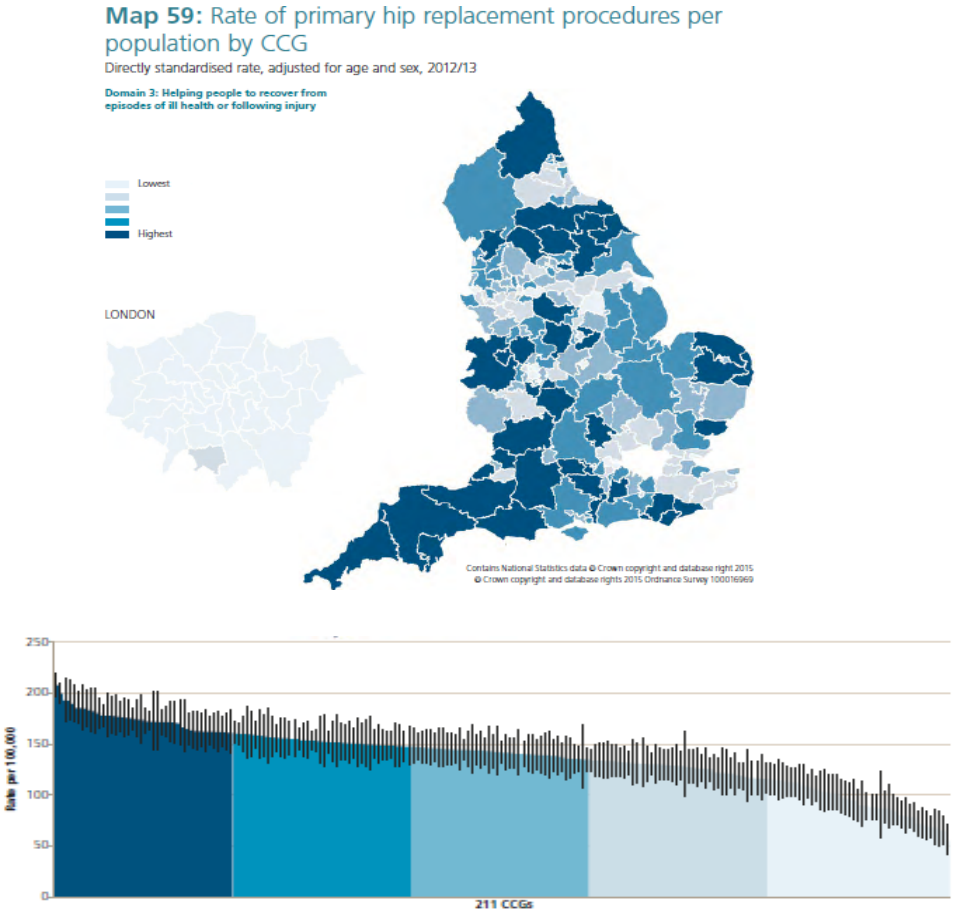
From the Carter Review and GIRFT

- Deep wound infection rates vary from 0.5% to 4% among acute trusts
- Each is traumatic for the patient incurs additional costs of £50-100k



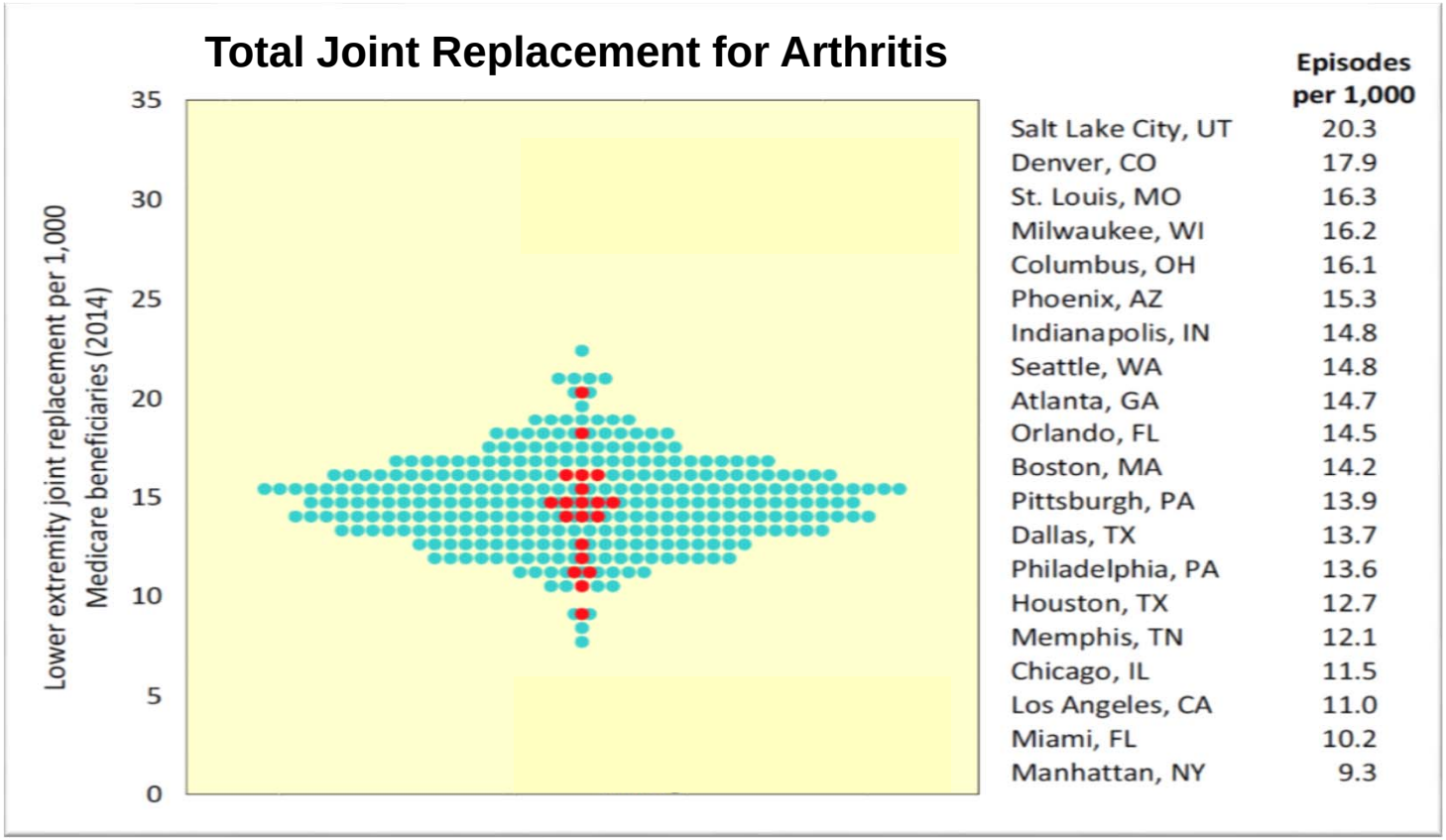
- Quantity of hip systems among trusts vary >15-fold with 1-7 brands
- Average price varies 2-fold from £788 to £1590

From the NHS Atlas and RightCare



Learning from Practice Variation in the US and Canada

Making Visible the Underlying Variation in Preferences



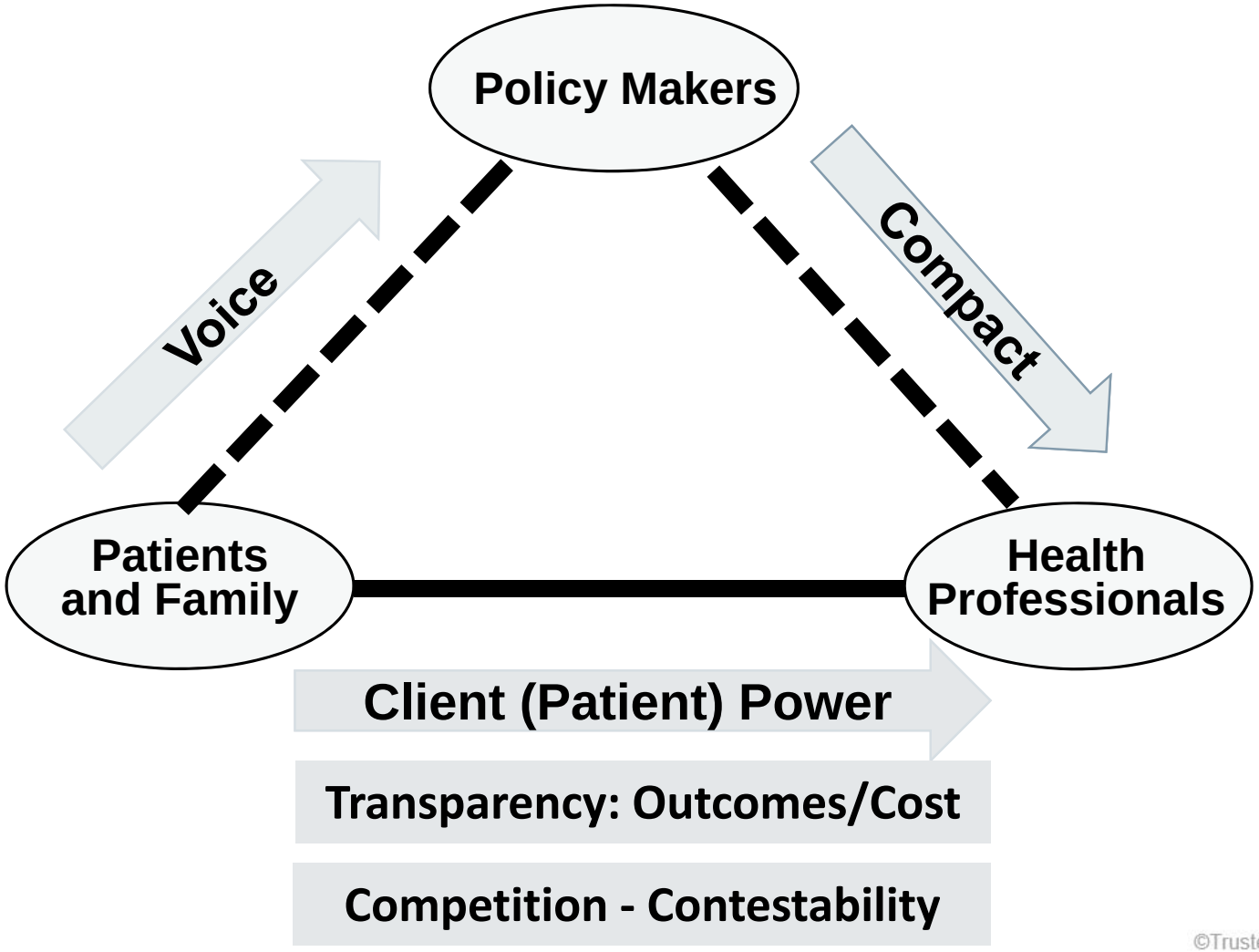
	Episodes per 1,000
Salt Lake City, UT	20.3
Denver, CO	17.9
St. Louis, MO	16.3
Milwaukee, WI	16.2
Columbus, OH	16.1
Phoenix, AZ	15.3
Indianapolis, IN	14.8
Seattle, WA	14.8
Atlanta, GA	14.7
Orlando, FL	14.5
Boston, MA	14.2
Pittsburgh, PA	13.9
Dallas, TX	13.7
Philadelphia, PA	13.6
Houston, TX	12.7
Memphis, TN	12.1
Chicago, IL	11.5
Los Angeles, CA	11.0
Miami, FL	10.2
Manhattan, NY	9.3

Dartmouth Atlas of Healthcare Analysis: 2016

Hawker GA, et al. Med Care 2001;39:206-16.

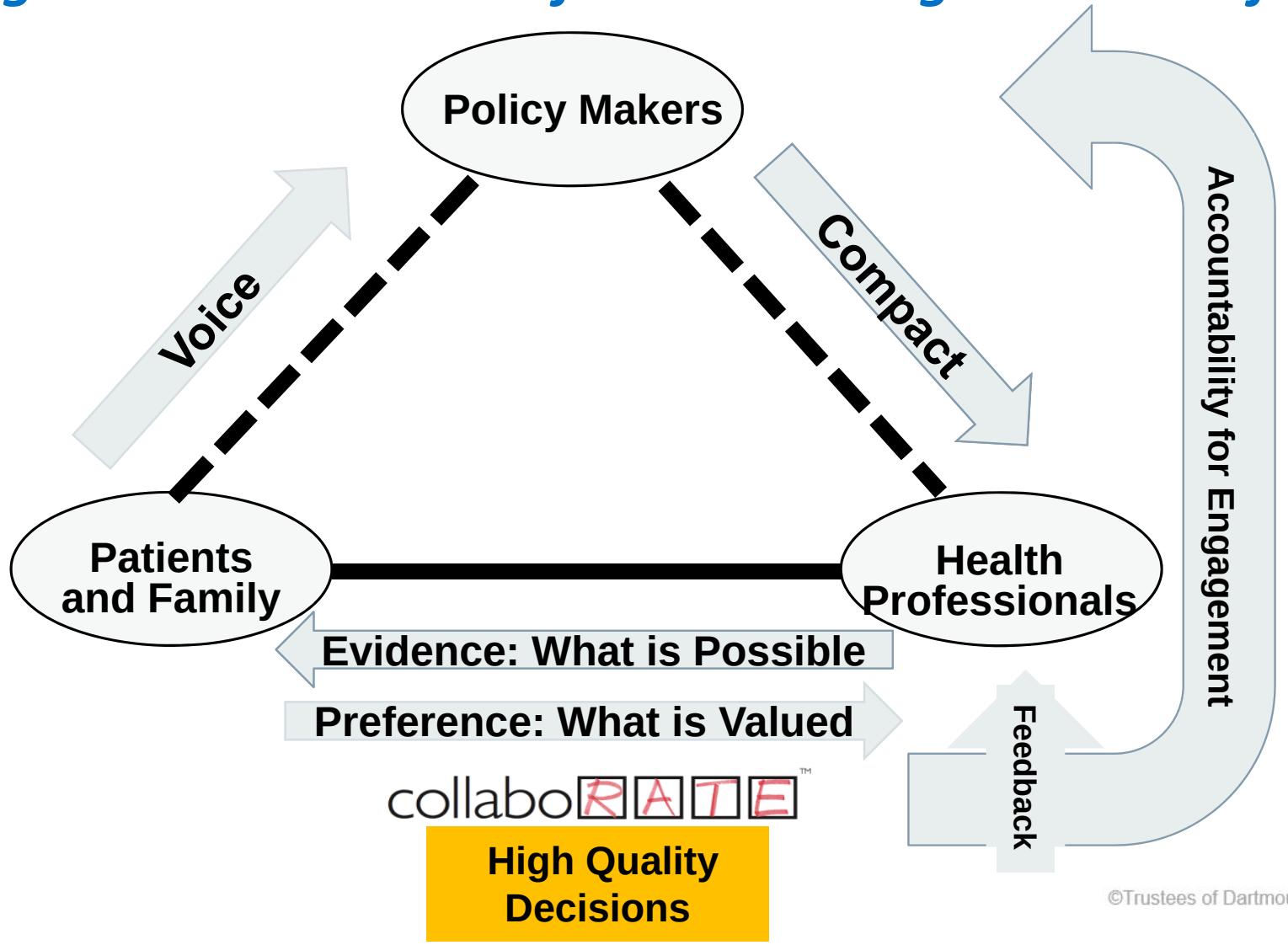
Learning from Variation to Deliver What is Valued

An historical perspective on market and government failure



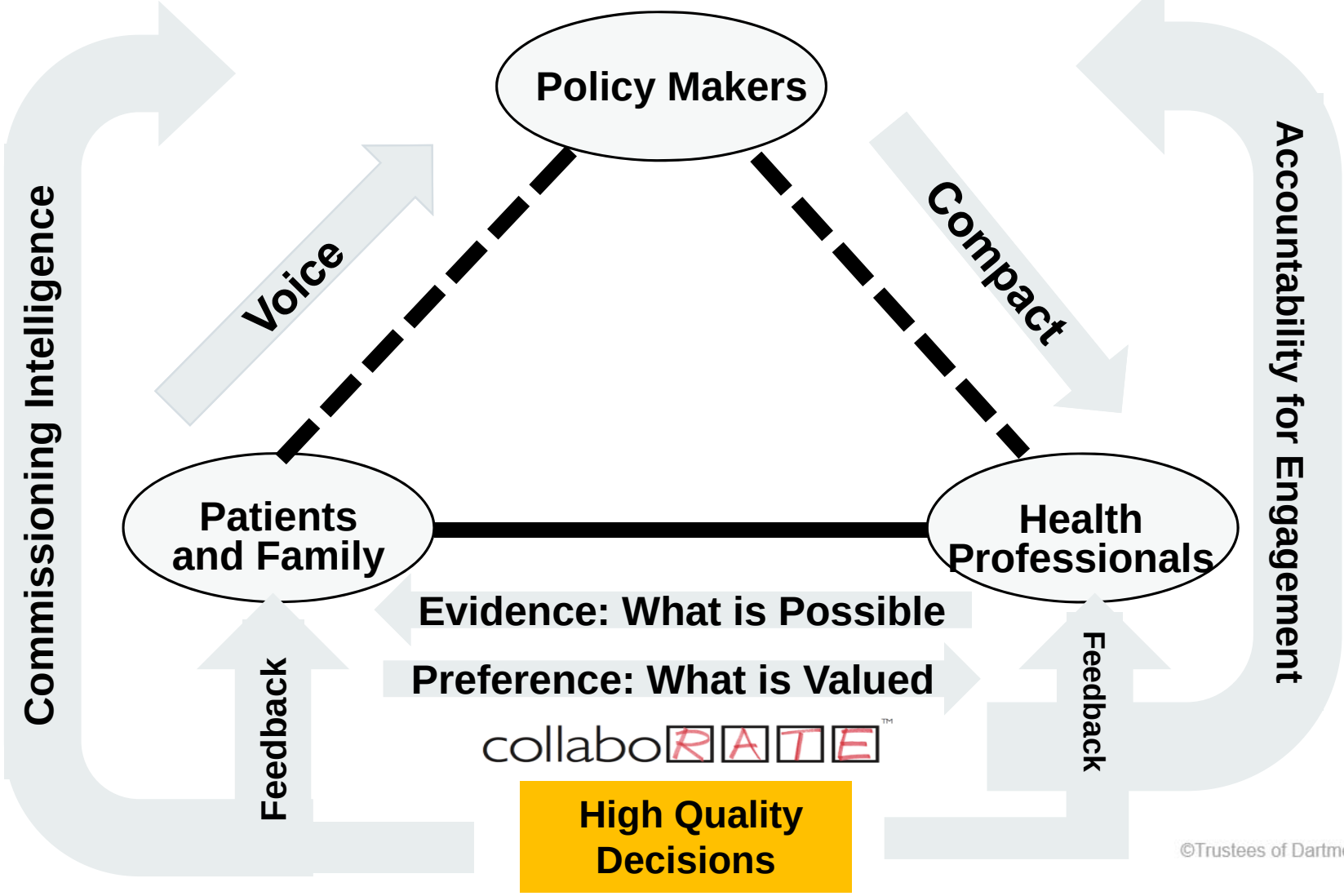
Learning from Variation to Deliver What is Valued

Confronting the critical source of market and government failure



Learning from Variation to Deliver What is Valued

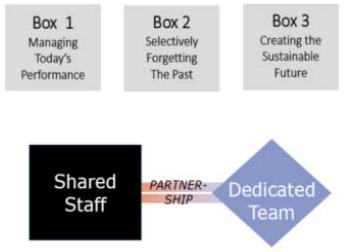
Confronting the critical source of market and government failure



Learning from Variation to Deliver What is Valued

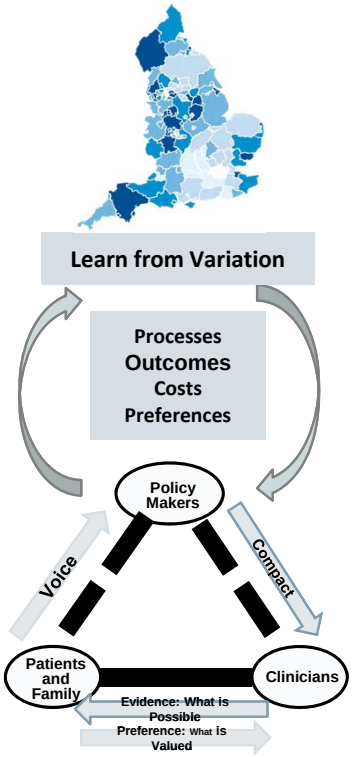
Overcoming conceptual and operational challenges

Operational Challenges | **Strategic Intent** | **Conceptual Challenges**

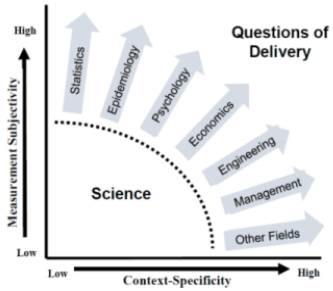


Organizing for Innovation

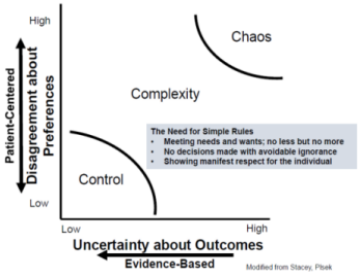
Delivering with Teams



Deliver What is Valued



Measuring What Matters



Managing for Accountability

Conceptual challenges include:

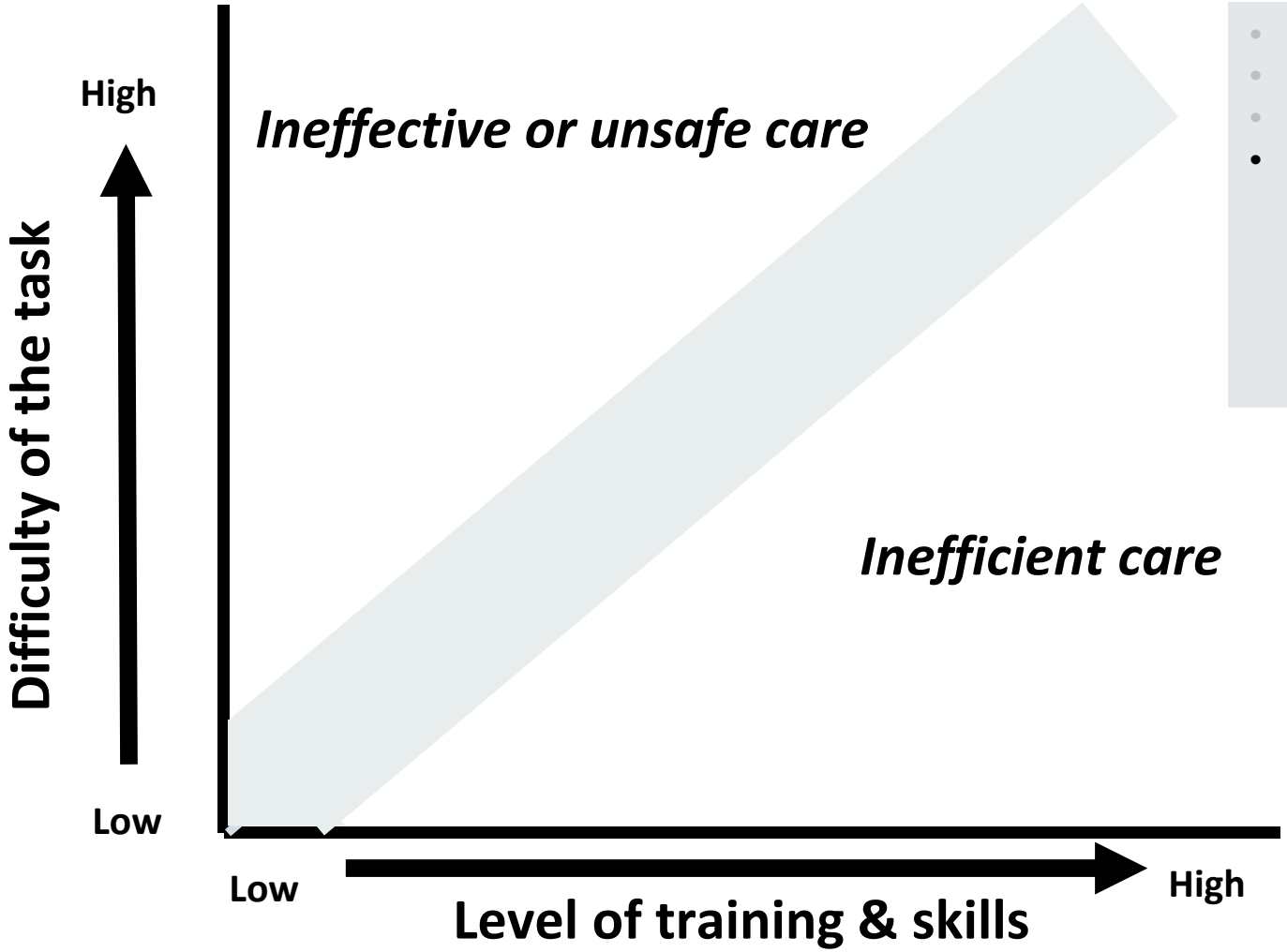
- ***measuring what matters*** among the people you serve; and
- ***managing for accountability*** among people who must depend upon each other to achieve system success

Operational challenges include:

- ***delivering with teams*** that include new roles designed for engagement of patients and families; and
- ***organising for innovation*** when improvement is not enough for success

Rethinking Roles and Teams for Innovative New Care Models

Supporting and Measuring the Teamwork Needed to Achieve Value

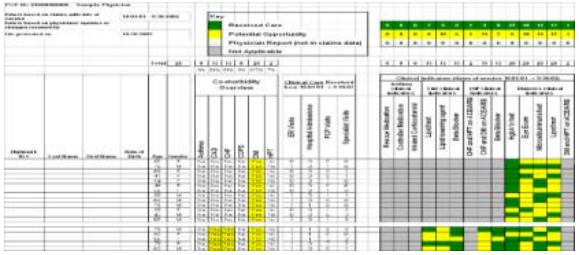


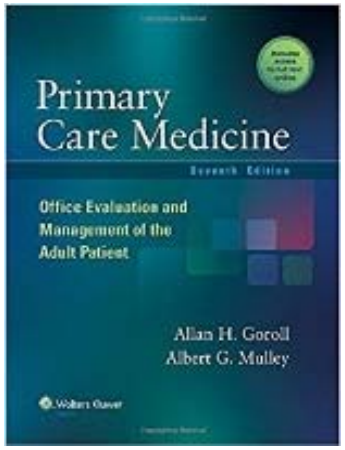
- Shared Goals
- Shared Knowledge
- Mutual Respect
- **Communication that is…**
  - **Frequent**
  - Timely
  - **Problem- solving**
  - Accurate

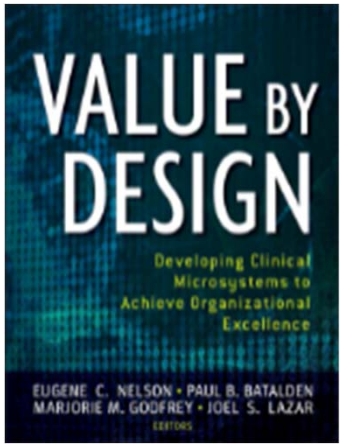
(Gittell)

Delivering Value with Teams in Innovative New Care Models

New Roles, Measures, and Tools to Capture Intelligence Needed for Sustainability







Teams with Roles Designed for Engagement

- Recruited for common lived experience, empathic communication skills
- Trained in shared decision making and motivational interviewing to understand needs, wants, and challenges patients face
- Avoid the substitution of high acuity care when it fails to meet needs and exceeds wants

Dartmouth HEALTH CONNECT

A Dartmouth-Hitchcock/Iora Health Primary Care Practice

Developing A Place Based Care Network (PBCN) for NHSE

Proposed Structure & Learning Objectives for a New Care Model Learning Network

MONTH 1

PLANNING FOR A PLACE BASED CARE LEARNING NETWORK

Work with vanguard teams individually to:

Review intended impact

- Who are the beneficiaries?
- What are desired outcomes?
- Is control over outcomes sufficient for accountability?
- Are they really achievable?
- How much time is needed?
- Can they be measured on an accurate and timely basis?

Review logic model

- What are the logic-defining cause & effect assumptions?
- How plausible if not proven?
- What are levers for change?
- What are learning priorities?
- Evaluation priorities?
- Will they support strategic , iterative tradeoff decisions?

Introduce coaching resources

- Surface questions to consider before first workshop
- Link each vanguard team to coaching support for virtual meetings and consultation
- Develop a common logic model adaptable to intended impact of each vanguard

MONTH 2

Revise Learning Objectives
Source Relevant Cases Source Metrics &Tools

WORKSHOP 1
Using Logic for Learning

- Confirm vanguards' intended impact logic including any revisions
- Identify metrics and tools needed to drive change
- Identify priorities for learning and evaluation
- Assess relevance of experience sourced from UK, US, other countries

WORKSHOP 2
Learning from Variation

- In process & outcome to improve quality/safety
- In practice & preferences to improve co-production
- In needs & wants of patients to improve value and health
- In local area contexts to implement innovation & adapt to achieve scale

Consolidate Learnings
Coach as Needed & Wanted
Prepare Preliminary Report

MONTH 3

Revise Learning Objectives
Source Relevant Cases Source Metrics &Tools

WORKSHOP 3
Delivering What is Valued

- Focus on vanguards' front line learning priorities for quality/safety & value
- Examine logic for local context and beneficiaries
- Identify opportunities for high value co-production
- Assess relevance of experience sourced from UK, US, other countries

WORKSHOP 4
Measuring What Matters

- Focus on patient-reported measures including needs and preferences
- Measure decision quality as well as process quality
- Measure engagement and co-production of care
- Achieve real-time data & feedback to learn & adapt while innovating for value

Consolidate Learnings
Coach as Needed & Wanted
Prepare Preliminary Report

MONTH 4

Revise Learning Objectives
Source Relevant Cases Source Metrics &Tools

WORKSHOP 5
Delivering with Teams

- Design microsystem teams for learning and meeting patients' needs & wants
- Fill each role with people working at highest & best use of skills and training
- Leverage skills with IT to support co-production
- Measure & reward care coordination by providers

WORKSHOP 6
Organizing for Innovation

- Distinguish innovation from improvement
- Hold dedicated innovation team leaders responsible for learning & adapting
- Ensure innovation leaders flexibility to define new roles within care models
- Identify and learn from similar efforts elsewhere

Consolidate Learnings
Coach as Needed & Wanted
Prepare Preliminary Report

MONTH 5

Revise Learning Objectives
Source Relevant Cases Source Metrics &Tools

WORKSHOP 7
Leading with Accountability

- Agree design principles for organizations & systems
- Focus on outcomes with improvement in quality & total cost of care
- Support patient choice & accommodate diversity
- Measure competencies & capabilities for risk based payment models

WORKSHOP 8
Governing for Stewardship

- Build IT for continued learning & improvement
- Govern with accountability for stewardship goals
- Lead with integrity of purpose and transparency in reporting to stakeholders
- Sustain system impact & value through reallocation of resources as needed

Consolidate Learnings
Coach as Needed & Wanted
Prepare Preliminary Report

MONTH 6

CONSOLIDATING LESSONS LEARNT TO BUILD AND SCALE PBCN(S)

Work with vanguard teams collectively to:

Consolidate learnings and assess value of experiences sourced from UK, US, other countries and related measures and tools to support a PBCN.

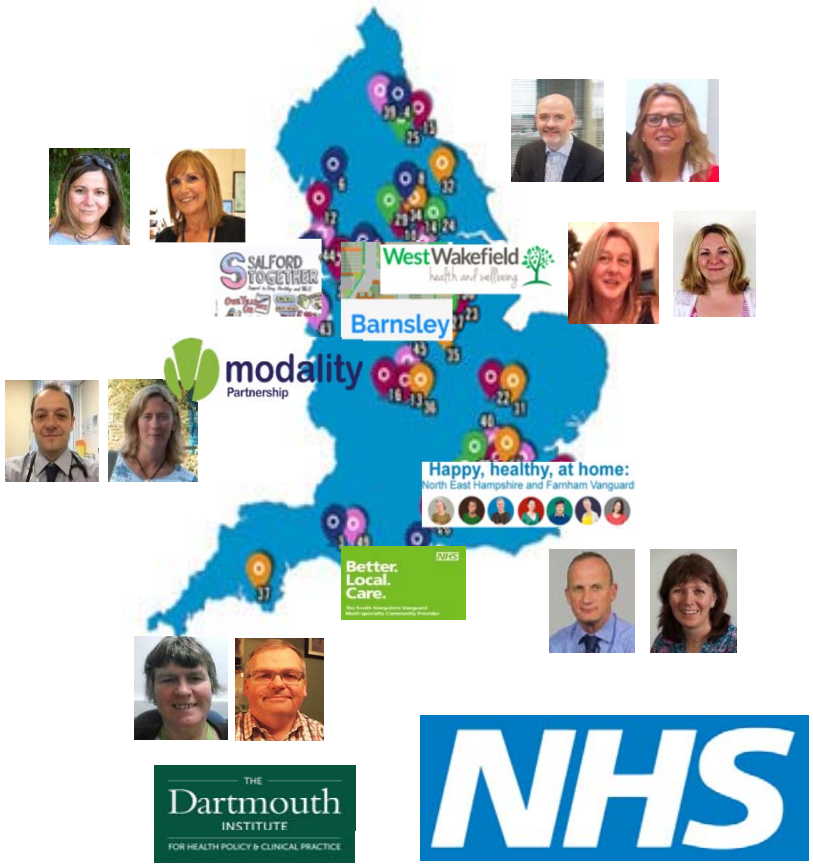
Recommend actions to be taken by the NCM, and NHSE and national bodies to support emergence of vanguards as learning organizations in a PBCN.

Advise on priorities for models, methods & metrics used in the UK, US, & other countries for adaptation to support a PBCN in NHSE.

Anticipate steps needed in future for expansion and replication to bring PBCNs to scale across NHSE working together with place based leadership of health and care services.

Co-Producing the Place Based Care Network Programme

Learning from Variation in Local Contexts across MCPs and PACSs



- Teams from 4 MCPs / 2 PACSs consisting of clinicians, commissioners, managers
- Guests from other vanguards → STPs
- Ongoing support from NCM and OR&E teams and others at NHSE
- Dartmouth team of 6+ senior faculty, a ‘chief learning officer’, UK colleagues
- Site visits months 1 & 6 were invaluable for learning and tailoring to local needs

Co-Producing the Place Based Care Network

Learning from Variation across the NHS and Beyond

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- Guests from other vanguards → STPs
- Ongoing support from NCM and OR&E teams at NHSE and others
- Dartmouth team of 6+ senior faculty, a 'chief learning officer', UK colleagues
- Site visits months 1 & 6 were invaluable for learning and tailoring to local needs
- Committed to ongoing engagement with others supporting vanguards → STPs
- Ongoing sourcing of ideas and evidence from Dartmouth and global partnerships
- Gathering international experience with focus on vulnerable populations

Essential Capabilities, Measures & Tools for Accountable Care

WORKSHOP 1
Using Logic for Learning

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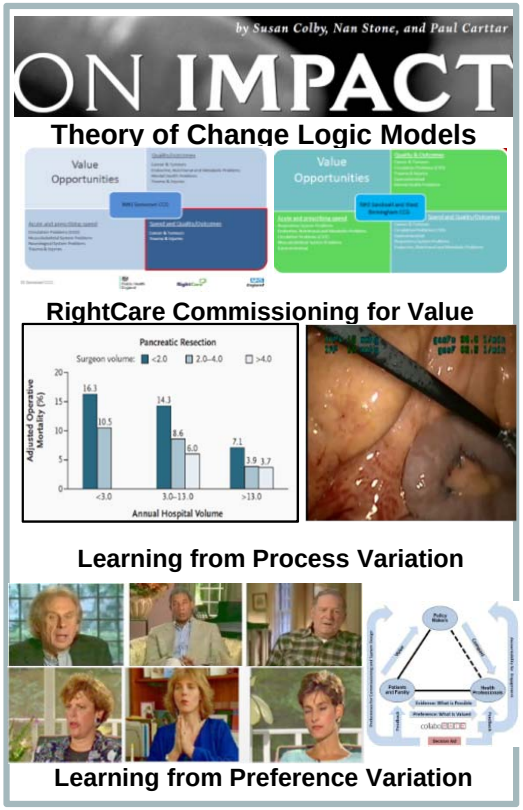
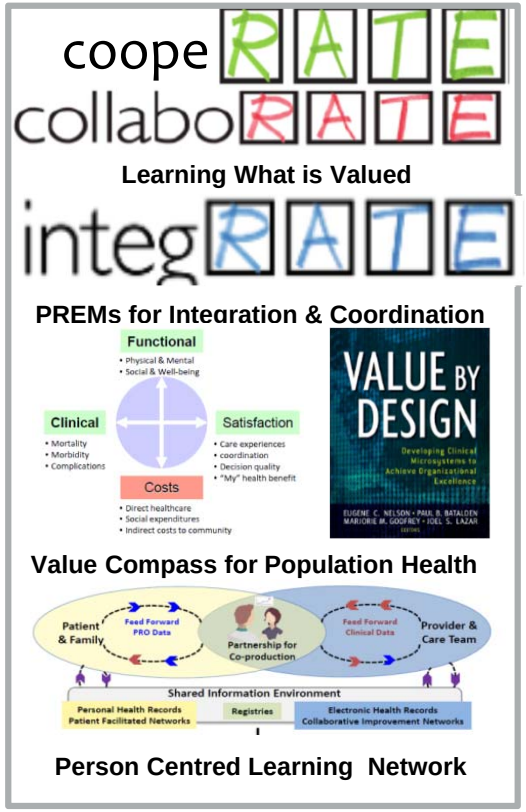


Theory of Change Logic Models

RightCare Commissioning for Value

Learning from Process Variation

Learning from Preference Variation

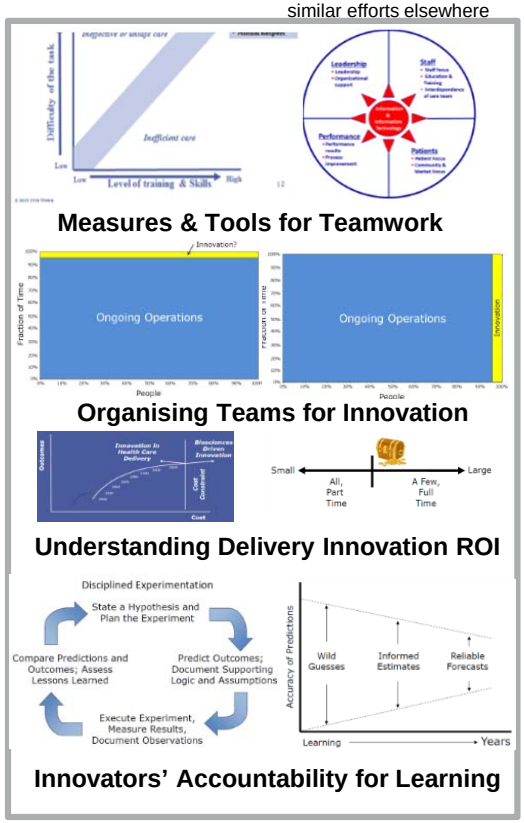


Learning What is Valued

PREMs for Integration & Coordination

Value Compass for Population Health

Person Centred Learning Network



Measures & Tools for Teamwork

Organising Teams for Innovation

Understanding Delivery Innovation ROI

Innovators' Accountability for Learning

New Care Model Canvas

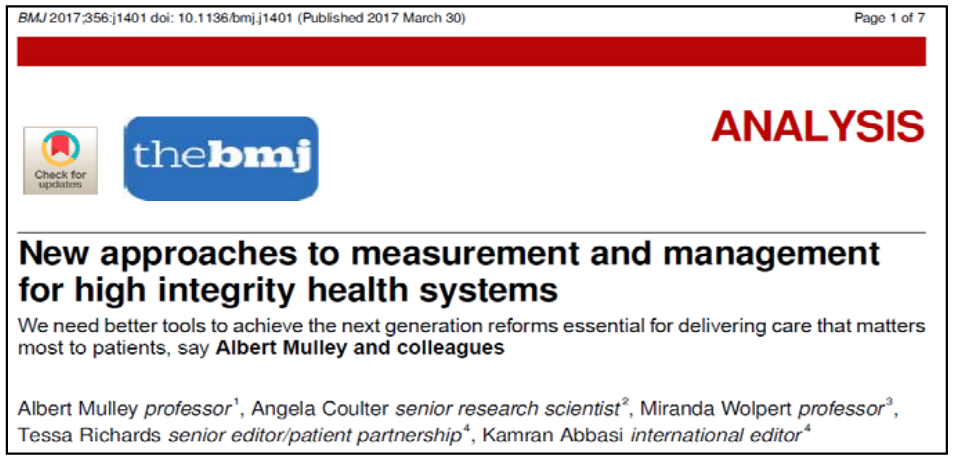
Strat Organisational Readiness Tool

ReThink Health & Wellbeing ROIs

Recognising Complementary Assets

Ongoing Evaluation and Adaptation of the PBCN

Partnerships to Refine and Expand the PBCN in Support of STPs → ACSs



BMJ 2017;356:j1401 doi: 10.1136/bmj.j1401 (Published 2017 March 30) Page 1 of 7

Check for updates

thebmj

ANALYSIS

New approaches to measurement and management for high integrity health systems

We need better tools to achieve the next generation reforms essential for delivering care that matters most to patients, say **Albert Mulley and colleagues**

Albert Mulley *professor*[1], Angela Coulter *senior research scientist*[2], Miranda Wolpert *professor*[3], Tessa Richards *senior editor/patient partnership*[4], Kamran Abbasi *international editor*[4]

Key Learnings

- The strategic intent and the actions needed to overcome challenges with new measures and tools were relevant
- PBCN teams put measures and tools to use in engaging within and across organisations in each of their localities
- The essential capability 'narrative' elicited common patient stories supporting the 'sustainability hypothesis'
- Refinement and expansion of the PBCN within team STPs was supported by willingness to serve as local faculty

Opportunities for Improvement

- Engagement and knowledgeable sponsorship from leaders
- Further 'flipping the classroom' for more actionable learning
- Coaching and technical support for 'tactical sharing'
- Curating examples of & evidence for mutual accountability

UCLPartners Academic Health Science Partnership

THE Dartmouth INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

NHS Health Education England

Commissioned by UCLPartners with funding from HEE to adapt the PBCN for NCL and NEL STPs

NHS RightCare

THE Dartmouth INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Working with RightCare to adapt PBCN learnings in support of STPs designated as ACS-ready

Dartmouth INSTITUTE

What We Have Yet to Learn about Accountable Care
Ongoing learning needs and emerging findings from the US

Ongoing Learning Needs	*What is Emerging from Research*
Conditions and capabilities for ACS cost and quality performance	Primary care; Clinician leadership; Priorities (eg, A&E); Organisational structure not predictive but role of partners in system may be
Conditions and capabilities for new forms of partnering within and across organisational boundaries	More than 80% of ACOs entered new partnerships; motivated largely by need for complementary capabilities and risk mitigation
Conditions and capabilities for engaging patients and families in decision making and co-production	Early emphasis on primary care models with patient support personnel; Engagement associated with recognition by leaders, clinician training, monitoring and feedback

What We Have Yet to Learn about Accountable Care
Where the NHS can lead in learning

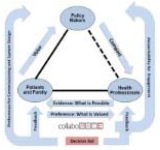
Ongoing Learning Needs	*Priority Learning Opportunities*
Conditions and capabilities for ACS cost and quality performance	Effect of financial incentives and / or intrinsic motivation on performance
Conditions and capabilities for new forms of partnering within and across organisational boundaries	Effect of using new measures of collaborative capacity, and tools for mutual accountability across roles
Conditions and capabilities for engaging patients and families in decision making and co-production	Effect of new clinical team roles on populations vulnerable because of complex health & social care needs

Bringing Together the Why, the What, and the How of Accountable Care

Measures & Management Tools for Mutual Accountability Across Health and Care Systems

# of stakeholders with role interdependences

Tools:
CollaboRATE
IntegRATE



integRATE
collaboRATE

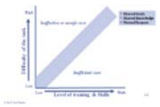
Patient & Clinician Reported Measures of Care Coordination & Teamwork

Patient & Clinician Reported Measures of Engagement to Agree Goals, Needs & Wants

Tools:
- Value Compass
- Microsystem Tools

Value Compass: Measures of Quality & Cost with Focus on What Matters to People Served

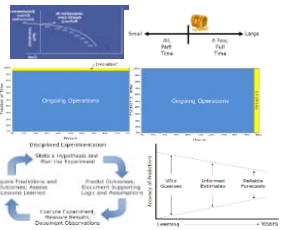
Measures and Tools for Quality & Efficiency Improvement in Clinical Microsystems



Tools:
- Right Care
- NHS Atlas
- 3-Box thinking

Measures to Learn from Variation in Outcomes & Costs; in Preferences & Personal Value

Tools to Guide Implementation of Innovation, Learning from Success & Failure



Measures to Assess Health Organisations' Readiness to Deliver Accountable Care

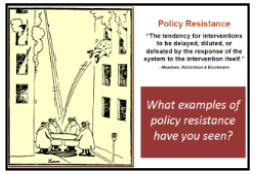
Tools to Partner for New Care Models Across Health Services with Needed Capabilities

Tools to Assess Health & Care Organizations' Readiness to Deliver Accountable Care

Tools to Partner for New Care Models Across Health & Other Sectors with Needed Capabilities

Tools:
- STRAT:Readiness Assessment for Health Care Organisations
- New Care Model Canvas for Health Care Organisations

System Dynamics Models to Test Impact and ROI Assumptions about Cross-Sector Investments



Tools:
ReThink Health

Frontlines of Delivery — **System Leadership**

The Dartmouth Institute for Health Policy & Clinical Practice