

2010 Military Health System Conference

MHS Strategic Imperatives – Applying Them to Your Organization

Sharing Knowledge: Achieving Breakthrough Performance

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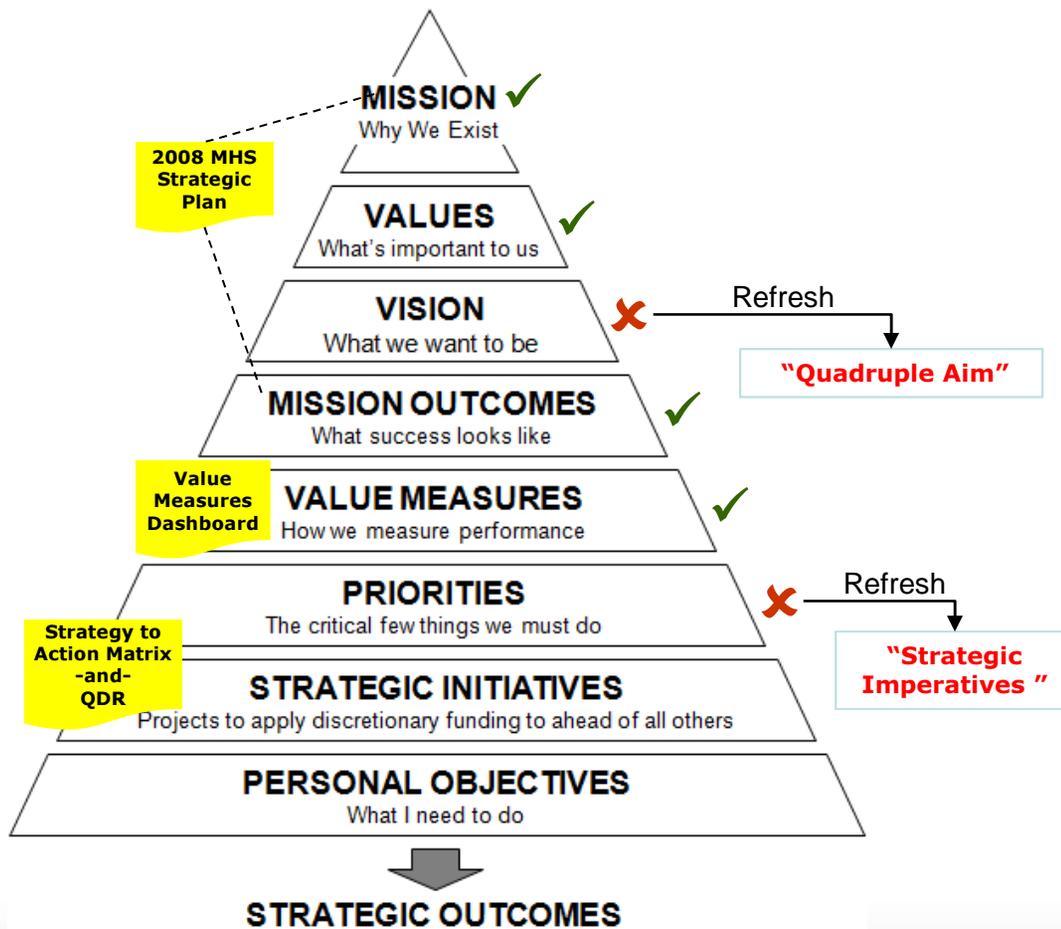
OASD (HA)

Objectives of this Briefing



- 1. Describe how the Quadruple Aim and Strategic Imperatives build on our 2008 Strategic Plan**
- 2. Explain improvement opportunities, or “Strategic Imperatives”**
- 3. Discuss how a focus on Strategic Imperatives can turn MHS Strategy into Action at each of the sites where you work.**

The 2008 MHS Strategic Plan – Strengths (✓) and Weaknesses (✗)



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- **Mission (mission elements)** more effectively describe the facets of the MHS mission than previous strategic plans
- **Mission Outcomes (strategic plan)**- clearly describe the expectations of our customers and investors and have enduring stability
- **Value Dashboard**- accepted by leadership as good indicators of mission success, consistent with Services and JTF CapMed and developed refined by SMEs

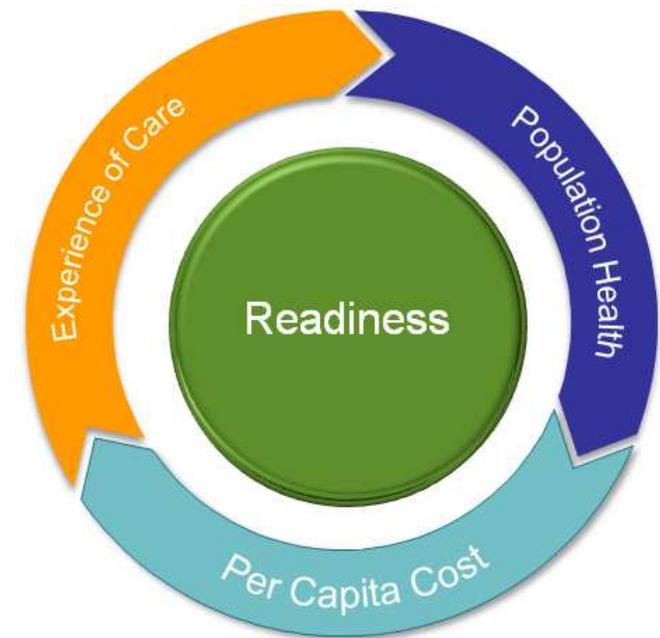
- **Vision** not memorable, not finite, not “what we want to look like and when”
- **Priorities** not explicitly linked to mission outcomes and performance measures, ineffective in guiding decision making and aligning the organization (e.g., Integration Councils , IM/IT Portfolio) , and did not drive strategic initiatives

How did we get to the Quadruple Aim



The Military Health System Quadruple Aim

- We published our most recent MHS Strategic Plan in 2008, and since then, leadership has used the plan to monitor and improve performance.
- In the fall of 2009, MHS leaders recognized that our plan is consistent with the concept of the Triple Aim plus Readiness





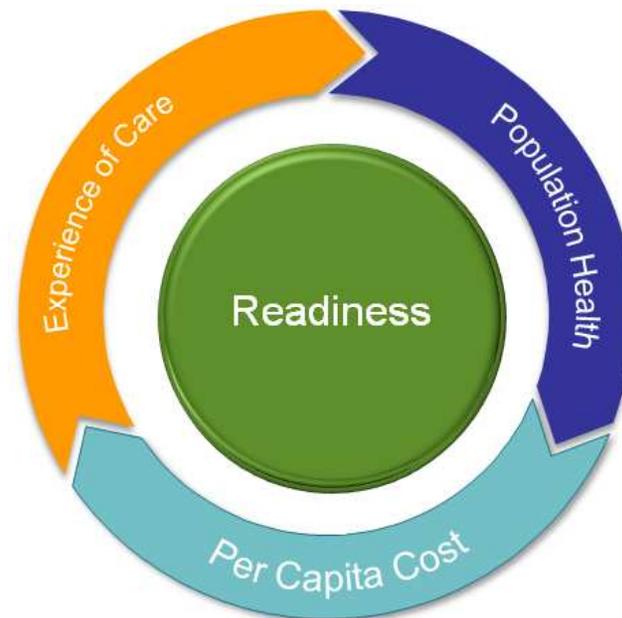
Overview – The Quadruple Aim

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.



Population Health

Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Refreshing our Vision – The Quadruple Aim



- Recently, MHS leadership endorsed a set of four aims to set our strategic direction—this is known as the Quadruple Aim*:

Readiness	Experience of Care	Population Health	Per Capita Cost
Ensuring a medically ready force and a ready medical force	Providing patient and family centered, compassionate, convenient, equitable, safe and high quality care	Improving healthy behaviors, reducing illness through prevention and increasing resilience.	Responsible management of cost; Incentives for value; Reducing variation and waste
<p>Mission Outcomes</p> <ul style="list-style-type: none"> Improved Mission Readiness Increased Resilience & Optimized Human Performance 	<p>Mission Outcomes</p> <ul style="list-style-type: none"> Effective Medical Transition (Coordinated Wounded Warrior Care and Services) Access to Care Beneficiary Satisfaction 	<p>Mission Outcomes</p> <ul style="list-style-type: none"> Healthy Communities / Healthy Behaviors Health Care Quality 	<p>Mission Outcomes</p> <ul style="list-style-type: none"> Performance Based Management

- We must also make focused investment decisions to support our people, enable the best decisions and promote a culture of innovation (This is not an “aim,” rather a foundation thread of our infras

Learning Organization	<p>Mission Outcomes</p> <ul style="list-style-type: none"> Deliver Info to Enable Better Decisions MHS Contribution to Medical Science Capable Medical Workforce
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Strategic Imperative Definitions



Mission Outcome	Strategic Imperative	Definition
Improved Mission Readiness	Individual Medical Readiness	Although we continue our pursuit of all aspects of readiness we will focus on increasing the proportion of the Total Force (Active and Reserve Components) that has a known readiness status and on reducing the rate of deployment limiting conditions.
Increased Resilience and Optimized Human Performance	Psychological Health	Improving health outcomes for the 20-30% of OIF/OEF Service member that report some form of psychological distress. Continued focus on research into and adoption of evidence-based care treatments for PTSD and TBI.
Healthy Community / Healthy Behavior	Engaging Patients in Healthy Behaviors	Encouraging and incentivizing patients and families to take a more active role in their health. Promoting a shift from “healthcare to health” by fostering the adoption of healthier lifestyles, particularly the reduction/elimination of tobacco and alcohol usage, increase in physical activity, and improvement in nutrition.
Health Care Quality	Evidence-Based Care	Transitioning from intuitive medicine to precision medicine through the development, proliferation, and adherence to evidence-based guidelines. Achieving lowest decile performance in the Dartmouth Atlas measures by reducing unwarranted variation.
Effective Medical Transition	Coordinated Care for Complex Cases	For medically and socially complex patients, establishing partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among multiple providers of care.

Strategic Imperative Definitions (Cont'd)



Mission Outcome	Strategic Imperative	Definition
Access to Care	24/7 Access to Your Team	Patients are provided information about how to access medical care at any time, 24 hours per day, every day of the year. Access may be in-person, by phone or by secure messaging using enhanced technology.
Beneficiary Satisfaction	Personal Relationship with Your Doctor	We seek to ensure that all primary care visits are with the same provider or team which is responsible for providing health care needs or arranging care with other qualified professionals. Care is personal, the PCM and the entire team listen carefully to the patient and, when appropriate the patient's caregivers. Compassionate, individualized and easy-to-understand education is part of every encounter.
Performance Based Management	Value-Based Incentives and Reimbursement	Shifting from volume-driven to value-driven health care by implementing performance-based payments focused on improving health outcomes over time.
Deliver Information to Enable Better Decisions	Functional EHR	Improve the Electronic Health Record family of applications to create a comprehensive, fast, easy to use, and reliable system that supports the quadruple aim by enabling better decisions, especially at the point of care.
MHS Contribution to Medical Science	Using Research to Improve Performance	Reducing the research-to-practice divide by focusing the R&D portfolio on the areas that will have the greatest impact on our strategic imperatives.
Capable Medical Workforce	Fully Capable MHS Workforce	Ensuring a thorough understanding of the job families most critical to our strategic initiatives and then developing/recruiting the right people to be a part of our team.

Strategic Imperatives Matrix



Strategic Imperative		Executive Sponsor	Performance Measure	Measure Status	Current Performance	Current Target	Target (2012)	Target (2014)
Readiness	Individual Medical Readiness	FHPC	Individual Medical Readiness		69%	80%	82%	85%
	Psychological Health	CPSC	Under Development		-	-	-	-
Population Health	Engaging Patients in Healthy Behaviors	FHPC	Under Development		-	-	-	-
		CPSC	Under Development		-	-	-	-
	Evidence-Based Care	CPSC	Enrollee Preventive Health Quality Index (HEDIS)		20	20	21	22
		CPSC	Overall Hospital Quality Index (ORYX)		87%	80%	83%	85%
Experience of Care	Wounded Warrior Care	CPSC	MEBs Completed Within 30 Days		40%	80%	-	-
		CPSC	MEB Experience Rating		47%	45%	55%	65%
		CPSC	TBD		-	-	-	-
	24/7 Access to Your Team	JHOC	Getting Needed Care Rate		74%	78%	80%	82%
		JHOC	Getting Timely Care Rate		75%	78%	80%	82%
		JHOC	Percent of Visits Where MTF Enrollees See Their PCM		39%	60%	65%	70%
		JHOC	Satisfaction with Health Care		58%	60%	62%	64%
Per Capita Cost	Value-Based Incentives and Reimbursement	JHOC	Under Development		-	-	-	-
		CFOIC	Annual Cost Per Equivalent Life (PMPM)		11.1%	6%	-	-
		CFOIC	Enrollee Utilization of Emergency Services		69/100	65/100	60/100	55/100
Learning & Growth	Functional EHR	CPSC	TBD		-	-	-	-
	Using Research to Improve Performance	TBD	TBD		-	-	-	-
	Fully Capable MHS Workforce	CFOIC	TBD		-	-	-	-

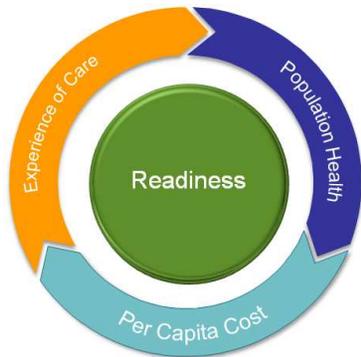
Legend: Concept Notional Measure Measure + Target (no out year target) Measure + Targets Measure + Targets + Initiative

Closing the Value Gap



1

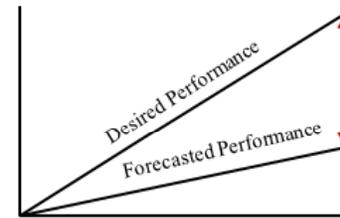
Clarify the Vision



2

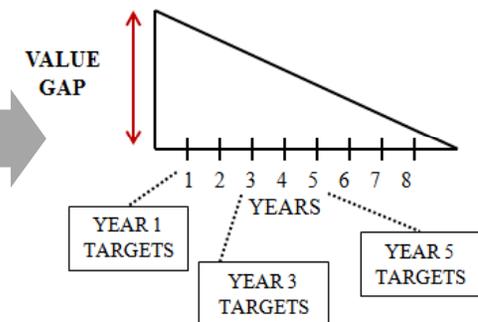
Translate the Vision (Aspiration) into a Value Gap

A screenshot of a budget spreadsheet with various columns and rows. A red oval highlights a specific section of the data.



3

Close the Gap Over Time



We are using the strategic imperatives to inform the development of the MHS budget and the IM/IT portfolio

Ten Options for Contributing to MHS Success in Achieving the Quadruple Aim



- ****Individual Medical Readiness**
 - Reduce IMR Indeterminant Rate (PHA/Dental Exams)
- ****Psychological Health**
 - Improve PDHA/PDHRA – Screening/Referral and Engagement
- ****Engaging Patients in Healthy Behaviors**
 - Promote Smoking Cessation – Counseling patients to quit smoking
- ****Evidence Based Care**
 - Identify your top three illnesses and implement a checklist
 - Strengthen your safety program
- ****Wounded Warrior Care**
 - Accelerate DES redesign Roll Out
- ****24/7 Access to Your Care Team**
 - Implement primary care redesign – Patient Centered Medical Home
- ****Personal Relationship with Your PCM**
 - Implement primary care redesign – Patient Centered Medical Home
- ****Value Based Incentives and Reimbursement**
 - Performance Planning Pilot Sites
- ****Functional Electronic Health Record**
 - Short term – MAPS, COMPASS. Secure Messaging
 - Long Term – EHR Way Ahead
- **Using Research to Improve Performance**
 - Refocus research portfolio to balance basic science with translational research
- ****Fully Capable MHS Workforce**
 - Apply the science of human motivation to every day leadership – autonomy, mastery, purpose

How do you focus your efforts?



- Pick three or four items based on:
 - Need for improvement
 - Capability to make improvement
 - Balance
 - Passion
- What is the balance you wish to achieve?
 - Quadruple Aim

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Four Possible Areas of Focus – The choice will likely be different at each site.



- **Individual Medical Readiness**
 - Reduce IMR Indeterminant Rate (PHA/Dental Exams)
- **Psychological Health**
 - Improve PDHA/PDHRA – Screening/Referral and Engagement
- **Engaging Patients in Healthy Behaviors**
 - Promote Smoking Cessation – Counseling patients to quit smoking
- **Personal Relationship with Your PCM**
 - Implement primary care redesign – Patient Centered Medical Home

What do you need to be successful?

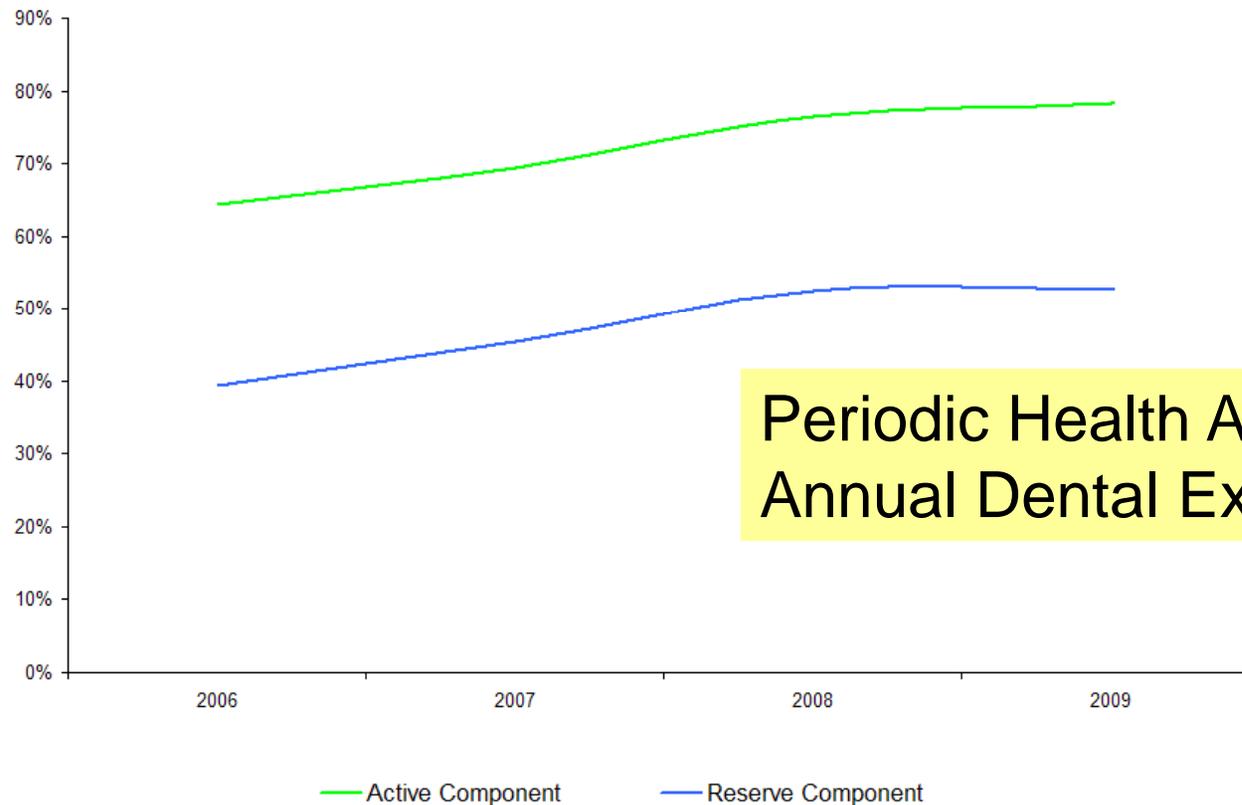


- An answer to “what is the problem we are trying to solve”
- Baseline and target on a measure of performance
- Commitment and accountability
- Resources

Where is the challenge in IMR?



Individual Medical Readiness



What do you do?



- Figure out how many active, reserve and guard are in your immediate area.
- Determine the current IMR rate
- Establish the gap between current and target
- Why does the gap exist? Ask why five times.
- Make a real plan to close the gap and commit resources?
- Establish accountability, get leadership support.

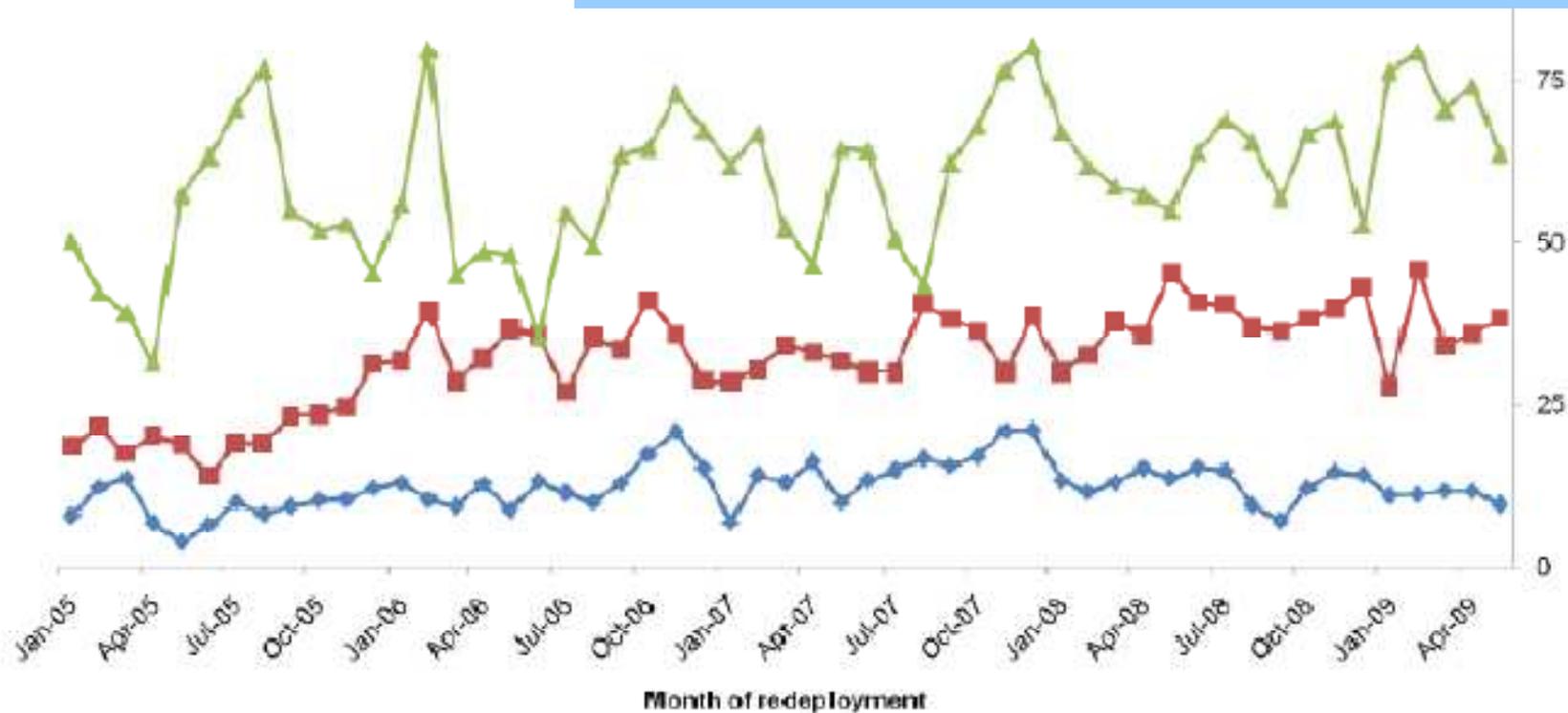
Where is the challenge in improving the process of identifying and treating post traumatic stress



PTSD screening, referral, and engagement US Armed Forces

- Percent screening positive
- Percent referred
- ▲— Percent followed up

Ensuring that all of those who would benefit from behavioral health services have ready access

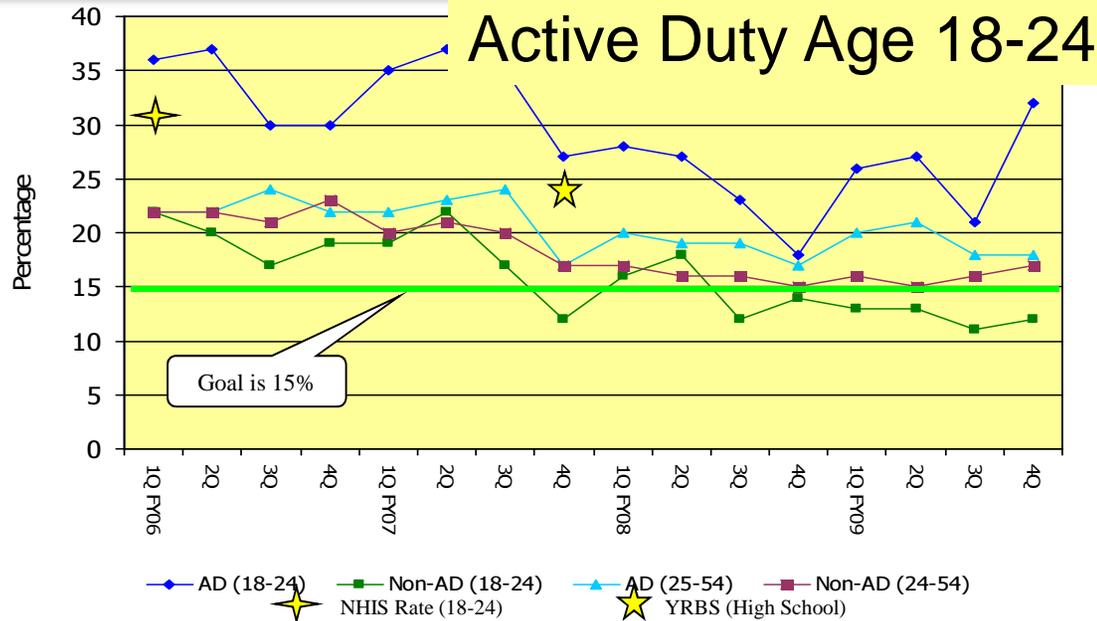


What do you do?



- Determine your role in performing PDHA / PDHRA evaluation.
- Review your processes for AD, Guard and Reserve access to mental health care
- Ask what you can do to influence the enterprise measure?
 - Improve consistency of PDHA / PDHRA screening process
 - Improve the quality of the referral and follow up process
 - Improve the acceptability of psychological support
 - Improve access to behavioral health in primary care or specialty behavioral health care
- Establish the gap between current and target
- Make a real plan to close the gap and commit resources
- Establish accountability, get leadership support.

Where is the challenge in reducing tobacco use?



Measure Advocate:

Dr. John Kugler
TMA-OCMO: (703) 681-0064

Monitoring: Quarterly

Data Source: Health Care Survey of DoD Beneficiaries

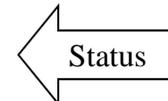
Other Reporting: None

Assessment Criteria:

R > 25 %

Y 15 - 25%

G ≤ 15%



Status

Current DoD Initiatives:

- 1) Parity pricing in PX/BX systems
- 2) Anti-tobacco marketing campaign
- 3) DoD advisory panel report on best practices to assist smoking cessation
- 4) Quit Line Demonstration project and possible CFR benefit change

What are we measuring?: This measures the incidence of tobacco smoking (not smokeless tobacco use) among four categories of MHS beneficiaries. All data have been converted to CAHPS 4.0 for consistency. This is survey self-reported data and is therefore subject to recall bias.

Why is it important?: Tobacco smoking among young people aged 18 – 24 is a particular focus of tobacco cessation efforts because difficult-to-change habits can be formed during these years and because young people aged 18 – 24 are generally regarded as the group most vulnerable for habit formation. This measure allows the MHS to assess the success rate of tobacco use cessation programs and other healthy lifestyle / health promotion efforts among specific high risk demographic groups.

What does our performance tell us?: Relative to the other categories, tobacco use among active duty service members aged 18 – 24 remains at very high levels. Tobacco use has not declined significantly over the last three years. Data from 4th quarter, FY07 to current has been recalculated to conform to CAHPS version 4.0, which dropped requirement to indicate when last smoked. This gives the appearance of reduced smoking, but that is not the case.

What do you do?

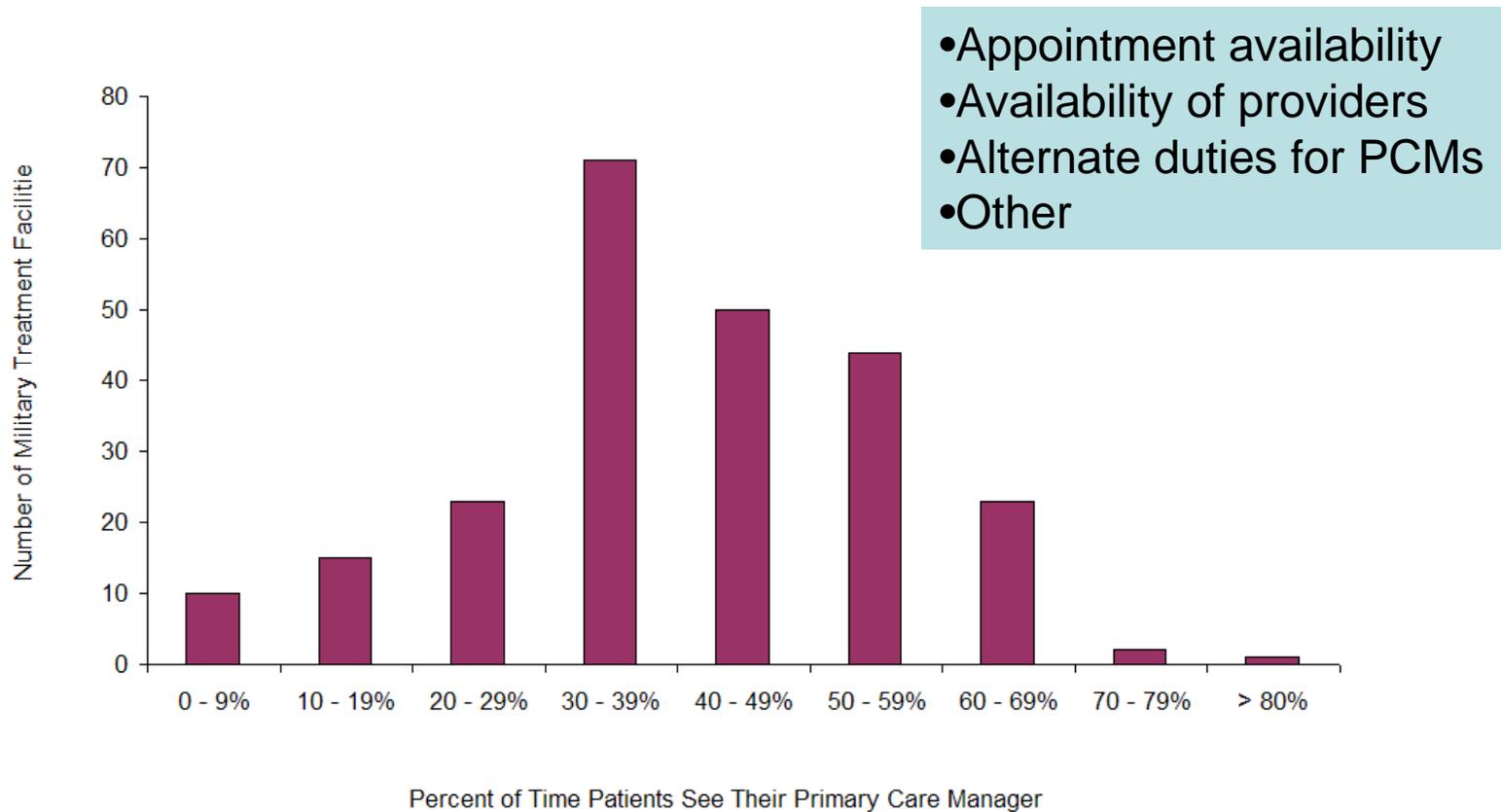


- Identify the population at risk – AD 18-24 among your enrolled population
- Review your process for identifying smokers and for counseling them to quit smoking
- Establish the gap between current and target
- Make a real plan to close the gap and commit resources
- Establish accountability, get leadership support

Where is the challenge in assuring that a person will see their primary care manager?



Primary Care Continuity



What do you do?



- Determine the percent of visits wherein enrollees see their PCM.
- Call a clinic that is having success, what is their secret? PCMH?
- Establish the gap between current and target
- Make a real plan to close the gap and commit resources
- Adapt then adopt solutions
- Establish accountability, get leadership support



■ Questions

What The Data Told Us: Strategic Imperatives will Focus on Improving Underperforming Areas



#1 – Casualty Care and Humanitarian Assistance	#2 – Healthy, Fit and Protected Force	#3 – Healthy and Resilient Individuals, Families and Communities	#4– Education, Research and Performance Improvement		
G <i>Reduced Combat Losses</i>	Y <i>Reduced Medical Non-Combat Loss</i>	Y <i>Healthy Communities/Healthy Be</i>	Y <i>Capable MHS Work Medical For</i>		
Case Fatality Ratio (OIF/OEF Combat Casualty) G →	Force Immunization Rate Y →	MHS Cigarette Use Rate Y →	Uniform Provider Fill Rates - Mental Health Specialties Y →		
Observed/Expected Survival Rate-Battle Wounds G →	Orthopedic Injuries Rate in Theater R →	Active Duty Lost Work Days Rate R →	Competitive & Direct Hire Activity - Medical Professionals Y →		
Mortality Rate Following Massive Transfusions G →	Orthopedic Injuries Rate in Garrison (Non-Deployed) G →	MHS Body Mass Index Rate Y →	<i>Advancement of Global Public Health</i>		
Battle-Injured Medical Complications Rate G →	Influenza-Like Illness Rate in Theater R →	FAP Substantiated Child/Spouse Abuse Rate G →	Under Development	X	X
Age of Blood in Theater Y →	Influenza-Like Illness Rate in Garrison (Non-Deployed) G →	Influenza Immunization Rate R →	<i>Advancement of Medical Science</i>		
R <i>Effective Medical Transition</i>	Psychological Health: In-Theater Evacuations/Encounters R →	Mental Health Demand-Family of Service Members X X	Peer-Reviewed Journal Article Publication Rate Op	<i>Healing Environment</i>	
MEBs Completed Within 30 Days	R <i>Improved Mission Readiness</i>	Active Duty Suicide Rate (Probable/Confirmed) R →	Under Development	X	X
DES Cases Returned to MTF	Deployment Limiting Medical Conditions R →	Y <i>Health Care Quality</i>	<i>Performance-Based Mgmt. and Efficient Operations</i>		
MEB/PEB Experience Satisfaction Rate R →	Undetermined Readiness Y ↑	Enroll Health Quality Index (HEDIS) Y →	Annual Cost Per Equivalent Life (PMPM) R →	<i>Deliver Information to People so They Can Make Better Decisions</i>	
VA Transition Process (Satisfaction with Records Availability) R →	R <i>Increase Resilience & Optimized Human Performance</i>	Overall Health Quality Index (ORYX) Y →	Enrollee Utilization of Services R →	<i>AHLTA Reliability</i>	
G <i>Improved Rehabilitation & Reintegration to Force</i>	Screening, and ment X X	CONUS Ventilator Associated Pneumonia Rate X X	Provider Productivity R →	<i>AHLTA Speed</i>	
Amputee Functional Re-Integration Rate G →		Health Care Personnel Flu Vaccination Rate X X	Bed Day Utilization (Prime Enrollees) X X	<i>AHLTA Satisfaction</i>	
Psychological Distress Screening, Referral and Engagement X X		Hospitalization 30-Day Disease Mortality Rate G →	<i>DMHRSi/EAS-IV Transmissions by Service</i>		
PTSD Intensity of Care X X		Y <i>Access to Care</i>	R →		
TBI Screening and Referral X X		No Problem Getting Needed Care Rate Y →	R →		
Potential Alcohol Problems and Referral X X		Percent of Time MTF Enrollees See Their PCM When PCM in Clinic Op	R →		
<i>Increased Interoperability with Allies, Other Government Agencies and NGOs</i>		Booking Success Rates for Primary Care Appointing Op	R →		
Under Development		Primary Care Third Available Routine Appointment Y →	X X		
<i>Reconstitution of Host Nation Medical Capability</i>		Y <i>Beneficiary Satisfaction</i>	R →		
Under Development		Satisfaction with Provider Communication Y ↓	R →		
<i>Strategic Deterrence for Warfare</i>		Satisfaction with Health Care Y ↓	R →		
Under Development		Satisfaction with Health Plan G →	R →		

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↑ Improving ↓ Declining → Stable (X) Under development