QUADRUPLE AIM UPDATE

Updated June 21, 2019

In May, Dr. Leonard Fromer, Executive Medical Director of the Group Practice Forum, gave a well-attended presentation on the Quadruple Aim. Dr. Fromer examined the role of provider satisfaction and joy in the workplace in conjunction with Triple Aim goals, discussed the successes and challenges experienced to-date in efforts to address this need, and offered insight into promising industry trends and opportunities.

A link to Dr. Fromer's presentation and talk can be accessed here: https://www.kinetixuniversity.com/peer-to-peer (Titled: The Quadruple Aim w/ Dr. Leonard Fromer)

Development of the Quadruple Aim

- Concept of Quadruple Aim stems from Triple Aim:
    - Improving Patient Experience
    - Improving Population Health
    - Reducing Costs

- The Triple Aim was originally formulated by Don Berwick (President Emeritus and Senior Fellow, Institute for Healthcare Improvement [IHI], and former Administrator of the Centers for Medicare and Medicaid Services [CMS]), as a framework for health systems to improve care and address:
    - Health disparities that contribute to increased risk
        - Demographic variations that are highly correlated with negative patient outcomes
        - External factors that limit patient access to treatment/care (e.g., income, zip code, race, health literacy)
    - Revenues as the paramount goal
        - Organizational strategies that improve profit over quality
    - Political barriers to implementing new regulations/practices
        - Individuals/organizations lobbying for healthcare changes due to alternative motives

- Stakeholders recognized physician burnout and the need to address this to achieve the Triple Aim
    - "Improving Care Team Satisfaction" became a fourth dimension and created the Quadruple Aim

Why Is the Quadruple Aim Important?

- The Quadruple Aim was established to ultimately drive population health
    - According to *The Third Annual Numerof Survey Report,* the main drivers of population health initiatives (in order of greatest significance) are:
        - Control over clinical costs, quality, and outcomes
        - Financial incentive programs tied to performance
        - Recognition that the fee-for-service model is not sustainable
        - Mission statements that drive organizational culture goals
        - Competitive advantage created in the market
        - Current/future government penalties

- The Quadruple Aim seeks to control rising healthcare costs that impact people in multiple ways:
    - Health care costs account for an increasing amount of household budget and gross domestic product (GDP) expenditure
    - Families often struggle to pay for care as incomes stagnate/decrease
    - Employers are shifting insurance premiums to employees by offering more plans with high cost-sharing structures
    - Due to federal, state, and local budget cuts, the government is under pressure to slow healthcare spending

- Since the early 2000s, there have been various initiatives, payment reforms, and advancements developed to address the shift towards value-based care

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Improving Population Health

What is it?	Improving health outcomes of a group, including the distribution of such outcomes within the group, via tracking, reporting, and managing new\outcome-based quality measures.
Why is it important?	About 10% of patients account for about 90% of the nation's patient-related costs.
How does it affect health systems?	Systems have identified the following core processes of population health management: define population, identify care gaps, stratify risks, engage patients, manage care, measure outcomes.
Points to Know	- Population health means improving care for a group of patients under the care of a provider – it goes beyond the individual patient's care - In many models, risk scores dictate reimbursement for a given set of patients - When contracting to determine patient outcomes, systems need to evaluate a baseline in order to track progress - The Hierarchical Condition Category (HCC) risk adjustment model indicates the level of risk/complexity associated with a given corresponding patient - This score impacts the budget allocated towards a given patient's care needs - System compensation and physician reimbursement are often dependent on value-driven metrics - There are government penalties for health systems that reach a certain number of readmissions in a given disease state

Enhancing Patient Experience

What is it?	Increasing the focus on how an individual experiences illness/injury, as well as the range of interactions that patients have with the healthcare system, and finding new ways to motivate and engage patients to play an active role in their care.
Why is it important?	Patients play a key role in their care and health systems can make changes that influence patient engagement levels. For example, patients normally pick up prescribed medications about 50% of the time, but this number increases to 94% when the patient receives a follow-up call after the visit.
How does it affect health systems?	Health systems are beginning to develop innovative methods for enhancing and measuring how engaged patients are with their care.
Points to Know	- Experience must incorporate the engagement level of that patient - Patient experience is results-focused and operationalized through metrics while satisfaction reflects a patient's perception of his/her experience - Successfully enhancing patient experience requires that patients take an active, rather than passive, role in their treatment plans - Barriers to successful patient engagement: - Health literacy gaps, unfilled prescriptions, poor health confidence, nonadherence, improper medication use, low patient engagement - New metrics for measuring patient satisfaction include: - Hospital Quality Initiative, Press Ganey Survey, HCAHPS - Net promoter score: One-question survey designed to gain insight on patient satisfaction - How loyal is the customer to the entity from which they are receiving a product or service? - Pharmaceutical companies have an opportunity to educate both patients and providers on the drugs that are available

Reducing Costs	
What is it?	Health systems are assuming greater financial risk with new value-based payment models and, in order to succeed under these contracts, are looking at strategies to reduce unnecessary costs.
Why is it important?	As of 2017, U.S. healthcare spending accounted for almost 18% of national GDP.
How does it affect health systems?	The shift from volume to value is forcing healthcare systems to find the least costly ways to treat patients without sacrificing quality.
Points to Know	- The two biggest healthcare cost drivers are (1) hospital admissions/number of days spent in the hospital and (2) emergency department costs - Breaking down costs: - Emergency department costs include: evaluation, diagnostics, pharmaceuticals, labor - Inpatient costs include: rooms, medical equipment, professional services, surgical procedures, labor - Outpatient costs include: pharmaceuticals, office visits, lab testing, diagnostics, labor - Health systems and providers have begun developing/utilizing population health-based centers to reduce hospital/emergency services use - Preventative care has become the new focus - Medicare Advantage - Private plans that are approved by Medicare to cover all of a patient's Part A and Part B benefits, and which also usually offer prescription drug coverage - There are many different types of Medicare Advantage plans from which patients can select depending on the services they anticipate needing most - The fastest growing insurance product (over 20 million members) - Taxpayers lose money on patients that are healthy but save money on patients that are receiving more costly treatment - Another approach to care delivery and payment is the direct primary care (DPC) model: - DPC offers another alternative to fee-for-service insurance, removing the financial barriers patients encounter in accessing routine primary care, including preventive, wellness, and chronic care services - Under the DPC model, patients are charged a flat membership to be paid monthly, quarterly, or annually. While most primary care services are typically covered, practices often suggest a supplemental, high-deductible plan to cover services that do not fall under the umbrella of primary care - The DPC model can help physicians avoid factors that contribute to burnout

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Improving Provider Satisfaction

What is it?	Health systems are working to prevent staff burnout and dissatisfaction by improving the work life of healthcare providers, including clinicians and staff.
Why is it important?	A recent study found that the physician burnout rate had reached 51% in 2017. The U.S. will face an estimated shortage of 50,000 physicians by 2020.
How does it affect health systems?	Healthcare systems are redesigning processes and workflows so that providers can spend less time on administrative tasks and more time on the actual treatment of patients.
Points to Know	• New providers enter the medical field believing that they will be able to focus almost exclusively on the patient-provider relationship. They do not realize how many external factors and administrative responsibilities they will also have to address: - Payer interference, utilization reviews, industry regulations, managed care rules, system protocols, and paperwork are some of the additional factors that require provider time and energy • "Front line" physicians (i.e., emergency care, internal medicine, and family physicians) are at greatest risk for burnout

Impact on Pharma

- Pharmaceutical companies have also started to participate in value-based contracting in order to reduce costs and improve quality

- Historically, pharmaceutical companies have not frequently partnered with health systems on population health initiatives
    - Pharmaceutical products are still paid for by health systems on a "by volume" basis
    - Pharmaceutical companies have been historically resistant to value-based payment models
        - Pharmaceutical companies face legal barriers, laws like the Sunshine Act that limit transfers of value between pharmaceutical companies and provider organizations

- More recently, pharmaceutical companies have recognized the need to shift and many have adopted models more closely aligned to value-based care. Changes include:
    - More collaboration among multiple stakeholders
    - Goal alignment and increased transparency to system decision makers
    - An expanded portfolio of products and services
    - An emphasis on developing services able to further Quadruple Aim goals alongside more traditional product-based engagements and offerings
    - Developing coordinated sales teams able to successfully navigate the complex value-based care landscape

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- Challenges to pharmaceutical field teams include:
  - Giving sufficient consideration to implementation processes
    - Pharmaceutical field teams must consider what the customer ultimately needs the resource to accomplish
- More large-scale pharmaceutical companies have entered value-based arrangements with health systems designed to improve one or more of the Quadruple Aim domains

Examples of Collaborations Between Health Systems and Pharmaceutical Companies	
Organizations	**Description**
UPMC & Boehringer Ingelheim	• Jardiance®- oral type 2 diabetes medication • Contracting has been active as of January 1, 2019 • Reimbursement for this medication is linked to the total cost of care for all people treated for diabetes

UPMC & Alkermes	• Vivitrol®-reduces risk of relapse in opioid-dependent patients
	• Goals of this initiative include:
	  - Improve medication adherence
	  - Support patients trying to avoid opioid dependence
	  - Remove barriers to access
	• Aligns the incentives of the manufacturer and health plan by linking reimbursement for the drug to positive clinical outcomes among UPMC members

Amgen & Cedars Sinai	• 3-year research partnership to improve treatment of cancer, cardiovascular disease, osteoporosis, and migraine headaches • Organizations will work on projects aimed at enhancing clinical outcomes, experience, and patient satisfaction • Combines Amgen's population health expertise and Cedars-Sinai's electronic health record (EHR) expertise to identify patients at-risk for developing chronic diseases • Cedars-Sinai hopes to expand programs related to precision medicine, care pathway redesign, diagnostic technology, and electronic medical records

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Merck & Geisinger	• Multi-year collaboration designed to improve patient health outcomes • Focus will be on adherence to clinical processes/treatment and on shared decision making between patients and physicians • Strategy is to find new points of intervention that will improve patient adherence to recommended treatment plans • The 1st of multiple deliverables will be an interactive web application that helps primary care clinicians assess and engage patients at risk for cardiometabolic syndrome • Metrics tracking patient acceptance of, and adherence to, recommended treatment plans will be used to determine which solutions are effective and should be expanded
Boehringer Ingelheim & Sutter Health	• 5-year research collaboration focusing on innovative healthcare solutions and treatment of chronic obstructive pulmonary disease (COPD) • Collaboration will leverage BI's R&D experience and Sutter Health's clinical expertise • Aims to test the value of digital health solutions, mobile technologies, and advanced data analytics insights in the delivery of health care • Goals of this initiative include: 　- Develop an electronic data collection system to be used during each health encounter with a patient 　- Improve treatment option communications between patients and healthcare professionals by integrating patient-reported and clinical data in an engaging visual display • Utilize visual displays/technologies to help connect patients and providers and create more personal care plans
Takeda & Advocate Health	• Partnership designed to study the effectiveness of a mobile app created to improve provider engagement with patients diagnosed with major depressive disorder

As pharmaceutical companies and health systems become increasingly receptive to value-based contracting and to the strategic partnerships that underly their success, identifying and acting on collaborative opportunities becomes increasingly important. TKG's long relationship with, and inside understanding of, both these stakeholders' goals allows our company to facilitate partnerships based on shared priorities, mutual goals, and inter-party trust.

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