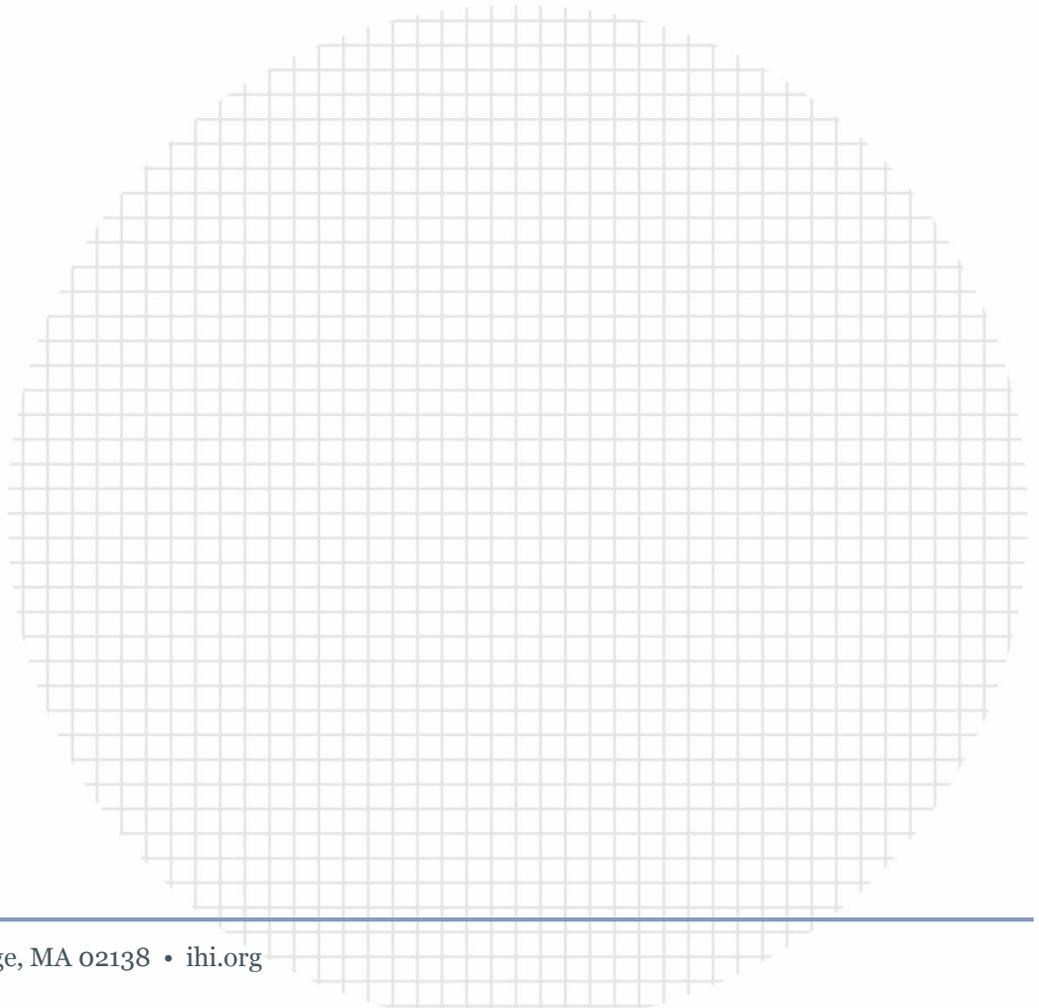




Healthy Shelby Initiative

A Triple Aim Improvement Story



AN IHI RESOURCE

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Introduction

In the past decade, much attention has focused on forming coalitions to meet shared community improvement goals. The Institute for Healthcare Improvement (IHI) has been instrumental in facilitating collective efforts to achieve the Triple Aim within communities and regions — that is, improve the experience of care and the health of a population while also reducing the per capita cost of care.

A vanguard of communities is pursuing a regional focus to improve population health through the broad lens of the social determinants of health. These communities are aligning the efforts of diverse stakeholders, spanning health and social care systems, faith communities, and local resident associations.

For those pursuing the Triple Aim for geographic populations, IHI offers specific guidance that emphasizes the following core components:

- Identification of a population for which the community holds itself accountable for the Triple Aim;
- A clear purpose, including what the community or region is trying to accomplish and why;
- An established portfolio of projects and investments to support the pursuit of the Triple Aim based on the needs and assets of the population;
- A means of governing and integrating the community initiatives and investments; and
- The creation of a learning system to track progress over time, including a cogent set of high-level measures that operationally define what a community means by health of a population, experience of care, and per capita cost of care.

IHI's guidance aligns well with the *Stanford Social Innovation Review (SSIR)*, which provides thought leadership in *collective impact* and identifies five conditions for shared success in collective impact: a shared vision for change, shared measurement and data collection, mutually reinforcing activities, continuous and open communication, and backbone support. In addition, the *SSIR* highlights the crucial role that backbone organizations play in collective impact initiatives, including the following activities: guiding vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding.

This Triple Aim improvement story examines the work of one such vanguard community pursuing a regional focus to improve population health, and the backbone organization that facilitates the local coalition.

Overview

The Context

The Healthy Shelby Initiative (Healthy Shelby) is one of five initiatives of Common Table Health Alliance, a regional health improvement collaborative in Shelby County, Tennessee. It provides leadership and backbone support for a broad stakeholder coalition: cultivating shared goals, collecting data from stakeholder groups, carrying out communication campaigns to increase public

awareness of health, and cultivating the adoption of innovative care methods. This Triple Aim improvement story describes how Healthy Shelby began its work to improve population health, how it serves as a backbone organization for the community's Triple Aim efforts, and how its governance structure supports the improvement of health outcomes in Shelby County.

The Coalition

Healthy Shelby is a public/private effort designed to improve the health of Shelby County residents and reduce the cost of medical care. The initiative links public health, hospitals, health care providers, social service providers, academic institutions, the faith community, local government, and funders to work together to tackle some of the county's most critical health problems: infant mortality, chronic disease management, and end-of-life care.

The Population

Shelby County has an estimated population of 939,365 (2013 estimate), and while 20.8 percent of the population lives below the federal poverty level, a large portion of Memphis-area residents are estimated to be underserved. The county population is 53.1 percent African American, 37.6 percent white, 5.9 percent Latino, and 2.5 percent Asian.

The Aim

Healthy Shelby describes its aim as the following: “We come together across our community to engage our constituents and leaders, align our resources, and coordinate our systems of care and services — to measurably achieve better population health, a better experience of care for patients, and lower per capita health care costs. We will achieve short- and long-term innovations which will improve the efficiency of health care, meaningfully advance health equity, and increase the quality and joy of life for all of the people of Memphis and Shelby County.”

The Triple Aim Story

The Healthy Shelby Initiative (Healthy Shelby) was a participating partner in IHI's Triple Aim in a Region initiative from 2011 to 2012, and in the IHI Triple Aim Improvement Community from 2012 to 2014. Healthy Shelby continues as an initiative of Memphis Fast Forward.

In January 2015, Catherine Craig, IHI Triple Aim faculty, spoke to Debra Bartelli, former Director of the Healthy Shelby Initiative, about lessons learned along their Triple Aim journey. The following is an edited version of that conversation.

Improving quality of life and increasing health equity is a huge task. Who decided on that focus, and how did it translate into action?

Community leaders, including the county and city mayors and leaders of many local health care organizations, came together in 2011 to discuss strategic health priorities and worked together with IHI's guidance to determine how to take on population health, experience of care, and cost of care — the Triple Aim. IHI's Triple Aim leaders, Dr. John Whittington and Niñon Lewis, helped our group look at local data to see what drives the cost of care, and that exercise also revealed key supporters of our future work.

We found that chronic disease drives a large portion of local health care costs and affects huge numbers of people in our county. Infant mortality rates were embarrassingly high, at 13 per 1,000 births in 2009, and both the county and city mayors saw great urgency to turn that around for the community. The Hospital Care Intensity Index from the *Dartmouth Atlas* showed that our hospitals were seeing very high costs of care in the last six months of life, so that was a pain point for all three hospitals.

The data was of broad interest: it brought to the table even the business community, who understand that poor quality of life discourages businesses and job candidates from coming to Shelby County. And the data led us directly to three initial projects for our portfolio of work:

- Reducing the impact of hypertension among black men;
- Preventing sleep-related infant death, an initiative we call “Safe Sleep”; and
- Improving end-of-life care, an initiative we call “Living Well/Dying Well” that aims to increase the number of people with advance directives.

The work to reduce hypertension was initially led from within the faith community. Hospitals and clinics partnered with churches to host hypertension screening events, pastors and a local NBA coach figured prominently in a media campaign, and church health ministers shared information on hypertension with congregants. The Healthy Shelby team also engaged the health care community and established a community hypertension data registry and a clinical care process improvement workgroup.

The Safe Sleep work is centered on activating the community and sharing information with new parents and families, which no one else in the community was doing in a coordinated manner.

For the Living Well/Dying Well work, our team quickly determined a key task: make advance directives the norm in the community. The specificity of the goal helped galvanize support among our partners and clarified next steps. Even though there were some initial disagreements among different partners about what to focus on, we came to agreement on advance directives by ensuring that our efforts are not redundant and that we provide resources to support ongoing work.

How are local organizations participating in Healthy Shelby's work?

Healthy Shelby has been very successful in engaging a broad range of groups — from the faith community, to health and public health organizations, to local celebrities — and cultivating ongoing participation in collective work. Partner organizations participate in any number of ways: they share data with us, staff health fairs, train their staff in advance directives, talk about our work to their members, and educate the public about Safe Sleep, the Five Wishes™ [i.e., a “living will” tool developed by Aging with Dignity that enables documentation of end-of-life care wishes], or hypertension.

Not all partner organizations are needed all the time, so you need to learn to call on certain people for specific parts of the work, and know who to rely on and who to push a little bit sometimes. And you need to recognize their strengths — for example, some partners never go to a meeting, but they contribute data to the registry.

Coalitions are fragile and require steady guidance. How is Healthy Shelby governed, and how did the governance structure develop?

We have a 35-member governance council that meets quarterly to advise on strategic direction. The council does not function as a nonprofit board, as Healthy Shelby is part of Common Table Health Alliance, the fiscal arm of Healthy Shelby, and has a board of directors. The governance council has an appointed chair and comprises funders, the city and county mayors, CEOs of four local hospitals and of local community health clinics, executive directors of local nonprofits and two foundations, and business, faith, and university leaders.

Each of the three focus areas (infant mortality, end-of-life care, and chronic disease) has a team and two co-chairs drawn from the organizations that carry the largest role in implementation or who are strategically aligned with the future of the work.

The history of Healthy Shelby is linked to Memphis Fast Forward (MFF), a collective impact strategic arm of Memphis Tomorrow, the corporate leadership group in Memphis. MFF came out of the shared vision of then Shelby County Mayor Wharton, Memphis Mayor Herenton, and the leadership of Memphis Tomorrow. Together, they drew up a strategic plan in 2005 around four areas: developing benchmarks for local government efficiency, economic development, public safety, and education.

In 2011, Healthy Shelby became part of MFF, expanding MFF's strategic vision to include health and wellness. Healthy Shelby came out of strategic discussions and planning by many community leaders, including the county mayor and leaders of many local health care organizations. MFF endorses Healthy Shelby's strategic priorities, advocates for policy reforms and finances, and includes our outcomes and process data in the MFF data dashboard.

Demonstrating the impact of collective work is one of the most effective ways to gain traction and maintain momentum in a coalition. What do you measure?

In the Living Well/Dying Well work we track outcomes such as Medicare costs in the last six months of life, and we have seen reductions in the percent of Medicare patients dying in the hospital and declines in Medicare costs. Process measures include the number of residents educated about advance directives, the number of Five Wishes documents distributed, and the number of audiences trained in end-of-life decision making. As of January 2015, 1,660 faith leaders, 27,952 hospital employees, 31,564 patients, and 4,312 individuals completed training on Five Wishes. We also track the percent of hospital patients with documented advance directives upon admission.

The infant mortality rate is our key outcome measure for the Safe Sleep programming. In 2006 the infant mortality rate in the county was 13.8 deaths per 1,000 live births and in 2013 that rate decreased to 9.2, representing a 33 percent improvement. Of course, it is difficult to estimate babies who survive as a result of Safe Sleep programming, so we track a host of process measures as well. We look at the number of people reached with Safe Sleep messaging campaigns, the number of volunteer Safe Sleep ambassadors deployed, the number of health fairs attended, the number of patients educated one-on-one, and a host of media indicators (e.g., numbers of social media "Likes" and mobile app downloads, and the numbers of views on YouTube and of movie theater advertisements and bus wraps).

Given the long-range nature of outcomes related to hypertension, we measure several processes: the number of patients and providers in the data registry, the number of community screening events, media coverage, and the number of public health advertisements (e.g., posters, television public service announcements). Over time, we will track the percent of patients in the registry with controlled blood pressure and the incidence of heart attacks and strokes in the community.

One challenge coalitions face is facilitating coordinated efforts such as data collection among partners. How does Healthy Shelby gather data from so many partner organizations?

The hospitals had worked together before, so they easily agreed to contribute data and had an existing level of trust. Even so, one of our clinical partners was reluctant to participate in the hypertension registry; we helped that partner get grant funding for another project, and then worked to convince them to join our hypertension registry effort. It took many meetings, and lots of time, but persistence won out. Other medical partners were reluctant to share their data and had concerns about the accuracy of each other's data. We started with the willing, and once the data showed that most providers were at the same level, that helped bring in the more hesitant groups.

What is holding back progress?

The data is a limiting factor, as we are not able to see data at a granular enough level to identify hot-spot neighborhoods to target for intervention. At the same time, politically we are not able to go to a specific census tract or neighborhood because it is seen as stigmatizing. That has held back some progress, as has the lack of adequate resources. It took us one-and-a-half years to get buy-in from organizations for sharing hypertension data with others — now we have more than 100,000 patients and 120 providers contributing data into the hypertension registry, and that is from competing hospitals and clinics. Politics also plays a role; we do not have a strong history of competing organizations in the county working together, so we realized we needed to start with the willing.

Sustainable funding can be difficult to establish, particularly for coalitions working to align the efforts of multiple organizations, many of which rely in part on grant funding. How is the work of Healthy Shelby funded?

Funding is not sustainable and is entirely through partner donations, which we get from the four local hospitals and the county and city budgets. Our budget was \$250,000 in 2012 and 2013; it was \$280,000 in 2014, which pays for Healthy Shelby staff: a full-time program director, a part-time administrative assistant, a program coordinator, and a data analyst. Partners will donate for specific projects; for instance, a local business helped fund our hypertension registry. We need a larger infusion of money, especially to do evaluation and promotion.

What do you wish you knew when you started this work?

How important it is to start with something that will produce results early to keep people hopeful, which is not something we did. In lieu of that, it is helpful to learn how to elevate the process as an important element. For example, Living Well/Dying Well did that when we shared data on the number of people who have learned about advance directives or taken a Five Wishes form. You have to find smaller aspects of the work to celebrate and get behind. Also, learning about infographics early on would have been helpful — our first-year report was text heavy, but last year's was entirely an infographic.

So much of Healthy Shelby's work is centered on messaging and sharing information. What have you learned about messaging to different stakeholder groups?

Messaging has to be consistent and repeated, even within the health care community. It is not a one-time effort. Among health care professionals who agreed to take part in the messaging, they were not always telling families the appropriate or consistent messages (about advance directives, or hypertension, or Safe Sleep practices), so we do continuous messaging to these professionals as a reminder. For the public, you have to use multiple channels to get the information out — sharing information at health fairs and on local cable television channels, putting signs on buses, and having the faith community lead the way.

In the Safe Sleep work, for example, identifying the target population for our messaging was really difficult. Hospitals are great about getting information to new parents or patients seeking prenatal care, but grandma or an older brother might be the baby's caretaker, and then there are the day care centers — and these other family members and groups were not necessarily receiving the Safe Sleep information. There are 14,000 babies born each year in Shelby County, but lots of people come in contact with and care for infants, and every year it is a new population. Even though most infant deaths occur in a small subpopulation living in poor, crowded conditions, where the baby sleeps in bed with a parent, it is politically difficult to do targeted outreach because it feels stigmatizing. But one of our partner organizations is beginning to do place-based home visiting.

The Living Well/Dying Well work was successful in getting to scale quickly, reaching between 80,000 and 90,000 people in less than 18 months. What specific interventions did you implement to get to scale?

Once we had our goal — to increase the number of people in Shelby County with advance directives — we decided to use a train-the-trainer approach. Two hospitals took the lead. Baptist Memorial Health Care Foundation funded a project to educate all employees on advance directives, and Methodist LeBonheur Healthcare followed suit. Both hospitals agreed to use the Five Wishes tool (created by Aging with Dignity), and spent two months in late 2012 training 15,000 to 20,000 staff members across the two hospital systems on the importance of having an advance directive and how to complete the tool. Surveys of hospital employees indicated high appreciation of the effort.

Simultaneously in 2012, the hospitals ran a three-month pilot project to test whether they could help patients complete an advance directive during their hospital stay. The pilot proved that a health crisis in the inpatient unit is not a productive time to complete an advance directive because the person's focus is on their immediate health challenges, their stress level is high, and completing the advance directive takes too much time.

The Healthy Shelby team realized that we needed to reach people while they are healthy and before they are in crisis. We developed a curriculum and a video, and in June 2013 we began offering community trainings — first to the business community and then to the churches, where hospitals already have ties. Baptist and Methodist hospitals are both linked to a network of churches they partner with to promote community health. These community health liaisons completed training in using the Five Wishes tool and began educating members of their congregations. We also offered training in a variety of other venues, including at Rotary Club meetings and in schools, and we continue to reach out to local businesses.

Then in early 2014, Healthy Shelby began working with physician practices to help patients complete an advance directive. We began with two practices linked to each hospital, reaching

primary care physicians, oncologists, and cardiologists. We have seen mixed results. The primary care physicians have done a great job, doing different tests on how and when to approach patients, and offering information on advance directives at the annual physical and at new patient visits. They have also tried sending letters to patients to ask if they want information about advance directives, and then they share the Five Wishes tool in the next visit. In oncology, it has been more difficult, with concerns about telling young patients that they need a living will. But now oncologists have started including the Five Wishes tool in the new patient packet.

For two years, we have held an annual breakfast meeting on National Healthcare Decisions Day. We targeted the first meeting for the business community and the second for the faith community, and we were able to bring the author of Five Wishes to give the keynote address.

What are the big accomplishments of Living Well/Dying Well, and what's next for this work?

Our efforts to increase the number of people who have advance directives are reaping benefits in people's ability to articulate their end-of-life goals and in practical changes in the way people die in Shelby County. We are already seeing the number of people dying at home or in hospice increasing and the number of people dying in the hospital on the decline. The latest report shows Medicare costs decreasing in the last six months of life. We cannot attribute the changes directly to our work, but the changes are exactly what we are working for.

As mentioned above, in under 18 months, Healthy Shelby has reached 80,000 to 90,000 people in the county through educational sessions and we have handed out more than 200,000 Five Wishes tools. We know that almost every person who has learned about the Five Wishes tool has a spouse, parents, or friends, and that the message is going beyond the people who attend the educational sessions.

Healthy Shelby is now developing a toolkit for primary care physicians, to help them use Five Wishes in their practices. We are looking at ways to use the stories of people who have completed an advance directive to get the word out even further. We are also developing common curricular material to train medical staff the same way about advance directives, whether they are pharmacists, nurses, social workers, or medical students, and we are expanding our focus to train the public and care providers about palliative and hospice care.

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