Roadblocks to Change:
Barriers to Achieving the Triple Aim in Community-Based Primary Care Organizations
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This paper addresses the problem of consistently unsuccessful practice transformation and quality improvement initiatives in primary care and community health organizations; including those which may be new, or existing efforts marred by ineffectiveness. These are targeted efforts to improve the most crucial clinical processes. These clinical processes most often make up the majority of services delivered in primary care organizations. James and Savitz (2011) quantify that just 104 out of 1,400 processes accounted for 95 percent of the total care delivery for a regional primary care organization in a high-need area. “In community-based primary care organizations, stakeholders have been slow to adopt and sustain practice transformation and quality improvement (QI) efforts. The case for practice transformation is evidenced by the impact of clinical errors on achieving positive health outcomes, which are relationship-based. Patients link approximately 70% medical errors to break-downs in the doctor-patient relationship (Rosenthal, 2008). When quantified in terms of daily encounters, in 2008, there were approximately 682 million office visits to Primary Care Providers (PCPs), which accounted for roughly 62% of the 1.1 billion outpatient visits nationwide, (Hing & Uddin, 2010). When contextualized in a community health setting, visit totals were approximately 55 million (Hing & Uddin, 2010). The importance of the problem has a significant financial impact as well. Errors incur significant costs associated with care delivery. In 2008, the estimated cost of all medical errors was approximately $50 billion (Van De Bos, et al., 2011). With the tangible and intangible cost of failure to implement quality improvement and practice transformation in mind, the purpose of this paper is to: 1) examine the construct of the Triple Aim, Practice Transformation, and the Patient Centered Medical Home (PCMH) model of care, 2) analyze the
issues and impacts of scoping, engagement and infrastructure as barriers to successful change, and 3) create a case for the impact and need for practice transformation and quality improvement initiative redesign, consistent with the Triple Aim and the PCMH model. This will be accomplished in two distinct but related sections. The Review of Relevant Research will explore the problem, its impact, and possible remedies, while providing evidence for each assertion. The Importance of the Problem will add context to the literature review and assess the impact of efforts, barriers and outcomes in a more global context.

**Review of Relevant Research**

The existence and impact of barriers to Primary Care QI and Practice Transformation, including the goals and models around which successful areas are designed, are evidenced by a comprehensive survey of recent literature (2008 to present). The literature review includes exploration of concepts (the Triple Aim, Practice Transformation, and Patient Centered Medical Home), identification and discussion of barriers to successful Practice Transformation and Quality Improvement, critical elements of initiative success, and an analysis of the value added to practices and organizations as a result of successful implementation.

Improvement in Primary Care and Community Health is built around the Triple Aim. The Institute for Healthcare Improvement (IHI) developed the Triple Aim as a set of goals that holistic improvements in healthcare should work toward. Those include, improving the patient experience of care (including quality and satisfaction); improving the health of populations (termed population health); and reducing the per capita cost of care (Institute for Healthcare Improvement, 2015) These goals tie to distinct but interrelated themes such as clinical outcomes, care affordability and cost, and patient experience. Each goal, and any associated theme, must be assessed from a strategic perspective when considering what
impact an improvement or change initiative might have. Berwick, Nolan and Whittington describe the Triple Aim’s complexity in a 2008 study of the concept, when its understanding was spreading globally to throughout healthcare systems and organizations. “The components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two, sometimes negatively and sometimes positively,” (Berwick, Nolan, & Whittington, 2008, p. 760). At its core, the Triple Aim is designed to serve as the DNA of clinical quality improvement, healthcare change, and practice transformation. While the Triple Aim is the ultimate destination, practice transformation is the means by which that change occurs.

Practice Transformation is a process which formalizes quality improvement efforts built around the Triple Aim into successive, segmented and specific initiatives. While linked to achievement of the Patient Centered Medical Home (PCMH) model of care, practice transformation is the means to that end, rather than the end itself. It is also a commitment which cannot return real results with short-term investments, but must have long-term intervention strategies which evolve over the lifecycle of the initiative, and even the organization (Crabtree, et al., 2011). The process of transformation involves projects directly applicable to the needs of the practice to which it is applied. While there are certain tenants that carry from one project to another, such as the link to PCMH, and the focus on achieving some or all of the goals of the Triple Aim, change management efforts must be tailored to the individual needs of the practice. Moreover, Crabtree et al. (2011) deepen the link by exploring alignment of practice transformation goals with an organization’s strategies, goals and available resources. The extent to which practice transformation is adopted, will depend in large part, on a primary care provider’s ability to effectively utilize resources, manage its
schedule, and create stakeholder buy-in (Castañeda, et al., 2012). Each article draws upon specific aspects of the impact and motivations of the Triple Aim, both allude to intangible aspects of the organization, such as culture, goals and attitudes. While practice transformation is the means of change and the Triple Aim is the goal, the PCMH model is a major achievement that change has been realized. Crabtree et al. (2011) draw the distinction that many transformation efforts are geared towards implementing the PCMH model of care; ultimately as a means of realizing the Triple Aim in practice.

Within the scope of the Triple Aim, quality improvement and practice transformation initiatives further the Patient Centered Medical Home (PCMH) model of care. Foy (2015) explains that “The Patient Centered Medical Home (PCMH) model is at the hub of transformative changes to address the triple aim” (p. 930). One of the cornerstones of the PCMH model is a team-based approach to care delivery. PCMH facilitates practice transformation through the use of active involvement by patients and members of the care team. Team-based care is seen as the nexus of all three goals of the Triple Aim. Through a review of related literature, Goldberg, Beeson, Kuzel, Love, & Carver (2013) find a considerable amount of research regarding the role of team-based care in improving patient safety, patient-centeredness, and health outcomes in primary care settings. For the high-need populations served by community health organizations, a care coordinator is an important member of the care team. Having a care coordinator with access to community-based resources, also addresses all three legs of the triple aim (Findley, Matos, Hicks, Chang, & Reich, 2014). With all of the practice transformation efforts geared toward meeting the Triple Aim fostered within the PCMH model, failing to properly plan and execute quality
initiatives can lead to a significant lack of success in making practice transformation a reality.

Improvement, change and transformation efforts are often hampered by poor scoping, planning and stakeholder engagement. A common cause of delayed or ineffective QI and Practice Transformation initiatives is lack of proper scoping, needs assessment, and stakeholder buy-in (Allan, Brearly, Byng, Christian, Clayton, & Mackintosh, 2014). Scoping is the foundational process by which improvement initiatives and projects are planned. Since scoping involves vital steps such as needs assessment, stakeholder identification, goal-setting and resource planning, many QI initiatives suffer from unnecessary redundancies in steps, wasted resources, and failure to achieve desired outcomes. One of the key resources often overlooked is data and business intelligences. A lack of accurate and usable data hampers initiative planning and execution. Most often, two systemic factors that affect improvement are: 1) a lack of infrastructure to collect and analyze data and 2) creating a strong link of data to decision-making (Alexander, Herald, & Shi, 2015). Second to resource planning, accurate engagement among all stakeholders and customers, even if they are identified as part of the scoping process, can prove detrimental to the success of quality and transformation.

Engagement from both consumers and employees is a bedrock of positive and sustained transformation. The consumer is the ultimate beneficiary of practice transformation; and consumer engagement drives value. If a consumer of any service does not actively use and engage with the service provider, there is an assumption that the consumer believes the service does not deliver value, thus significantly increasing the possibility of attrition (Bess, Prilleltensky, & Collins, 2009). Bess et al. (2009) find that end-user (consumer/patient)
participation in governance of community health and human services agencies dramatically affects the ability of an organization to drive and sustain change. As users of a service, consumers are in a unique position to create and test value. Castañeda, Holscher, Mumman, Salgado, Keir, and Foster-Fishman (2012) also expand upon one of the key points in Bess et al. (2009) of consumer-driven utilization. As an example, all Community Health Center (CHC) Boards of Directors must be majority consumer users (US Health Resources Services Administration, 2015). While consumer perspective, mindset and engagement are essential to transformational success, organizational staff drives change, and must be actively consulted, trained and engaged; from planning to review, is essential. Staff members who carry out change initiatives are sometimes overlooked. Change managers may fail to completely consider the feelings and emotional burdens of staff during periods of transition or uncertainty, and implementation of new initiatives at primary care organizations (Allan, et al., 2014). While engagement drives success, transformation cannot happen without the infrastructure.

Essential elements of the quality infrastructure include policy and regulatory frameworks, governance, and organizational culture. Regulatory requirements, governance processes and internal policies and procedures, which are not sustainably developed or implemented, cause barriers to effective improvement - even though they are often seen as vital to patient safety and quality. Primary care and community health, like other ambulatory and acute care providers, are subject to a highly complex framework of regulation and internal policies and procedures. If not managed effectively, complex policies and procedures, and tight regulatory restrictions stifle organizational change due to inflexibility (Allan, et al., 2014; Anders & Cassidy, 2014). Burdensome governance practices are echoed by consumers and
staff alike. Perception of excessive regulation by end-users can be seen as the fault of those carrying out the policy or initiative. Castañeda et al. (2012) key-in on a sentiment often echoed by organizations across primary care and community health spectrums, by specifically asking if employees are resistant or open to change, as part of a satisfaction survey. By re-imaging the infrastructure, practice transformation not only succeeds, but thrives.

Implementing practice transformation through redesigned governance practices has not only resulted in more widespread successful change, but also in a marked rise in staff productivity, as well as transformation of organizational culture (Castañeda, et al., 2012). Once a cultural transformation of change is underway, implementation of improvement techniques gains credibility. Anders and Cassidy (2014) utilize modern process improvement techniques such as interest relationship diagrams, mind-mapping, and systems analysis to critically evaluate the inputs and outputs of organizational strategic plans and associated business processes. At the same time, community-based primary care organizations can more quickly adopt practice transformation by building off of the team-based care approach of the PCMH model. Transformational development involves fusing the practice of team-based care with cohort-style learning. The Department of Veterans Affairs (VA) Health Care System is an example of a large-scale organizations implementing team-based care. Facilities within the health care arm of the VA create learning collaborative as an extension of care teams – collectively testing and implementing practice transformation efforts (Schetman & Stark, 2014). The need for strong practice transformation, thoughtful planning and engagement, and strong alignment with the Triple Aim and the PCMH model is clear.
Based on a review of relevant literature, a clear link exists between transformation, quality efforts, and the Triple Aim. These efforts are operationalized through the PCMH model, and can have significant positive impacts on care outcomes, cost and patient experience. At the same time, if proper planning and engagement do not drive initiatives, or they are mired in ineffective policies and practices, the best efforts will most likely result in failure to achieve stated objectives.

**Importance of the Problem**

Unsuccessful quality improvement and practice transformation efforts can negatively impact patient care outcomes, costs and experiences – both for the user and the provider. Practice transformation and quality improvement initiatives must be scoped to the individual needs of the organization in order to achieve the Triple Aim. With continued resistance to change, failure to plan and execute, and lack of buy-in, the cost of preventable errors will continue to rise, and the comparative detriment to population health outcomes will create more chaos within an already timid healthcare system, (Hing & Uddin, 2010). A variety of factors, such as primary care service offerings, size and scope of staff, patient population needs, and many others can affect how care teams are developed, and how they impact health outcomes from one patient to another (i.e. the population of the community-based primary care provider). Failure to properly align transformation efforts with the Triple Aim and widespread adoption of the PCMH model can aggrevatee already trepid patient perceptions of care, cause a significant increase in the cost of care due to preventable errors, and adversely impact population health on a global scale. Effectively scoping change and quality improvement efforts through the lens of the Triple Aim, with the PCMH model is an effective way to create sustainable practice transformation. One key strategy to affecting change is the use of Care Teams as part of the
PCMH model. Several studies (Goldberg, Beeson, Kuzel, Love, & Carver, 2013; Schetman & Stark, 2014) validate the optimal use of care teams, and the associated improvement in organizational behaviors such as communication and effective use of technology. Ultimately, using concepts such as team-based care and active patient involvement as a means for mapping practice transformation builds the inextricable link between consumers and care providers; validating every goal of the Triple Aim. To create maximum value for stakeholders, users and staff members, leaders should assess every project or initiative through the lens of the Triple Aim, use proper engagement and planning techniques, and assess validity of goals and efforts within the confines of available resources, organizational strategies and objectives, and the existing regulatory framework of the industry.
References


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