

Outline Of Marshall Plan Concept

1. Problem(s)
 - a. Rising health care costs & inconsistent quality of medical care
 - b. Poor health outcomes and health status relative to dollars spent
 - c. Disappearance of primary care despite evidence of value (Starfield, et al.)
2. Root Causes
 - a. Mal-aligned incentives (a societal/governmental solution needed)
 - b. Clinical miscues: mis-diagnoses, operative mistakes, etc.
 - c. Operational and logistic problems and failures
 - i. Lack of culture of quality and culture of continuous improvement
 - ii. Focus on blame not problem-solving
 - iii. Focus on individual not team
 - iv. Focus primarily on acute treatment not prevention and chronic care
 - v. Excessive waste at all levels of medical care
 - vi. Excessive variation in structure, process and outcomes of care
3. Attainable Solutions in Primary Care through application of industry-proven methods
 - a. Removal of waste using industry-proven process improvement tools and techniques
 - b. Sustainable re-engineering of practices to
 - i. Create and sustain cultures of quality, continuous improvement, team-orientation, patient safety, etc.
 - ii. Improve process improvement knowledge and skills in medical practices
 - iii. Evolve primary care practices into PCMH's
 - iv. Properly prepare practices for Health It
 - v. Improve patient safety
 - vi. Improve chronic and preventive services
4. Marshall Plan
 - a. Intro
 - i. Modeled after Post WWII program
 - ii. Concept: Make trained, experienced, properly oriented and sensitized, highly-skilled process engineers from industry available to primary medical practices to help them achieve objectives listed above in a proven, structured, supportive, and closely supervised environment
 - iii. Coaches are there to assist in improving operational processes and/or to assist in harvesting available but un-harvested income, i.e., payer or program incentives requiring practice re-engineering.
 - iv. Coaches NOT there to teach health care providers how to practice medicine.
 - v. Coaches not consultants, but teachers, mentors, guides, etc. There are there with a fishing pole to sustainably teach the practice to fish (i.e. continuous improvement culture and operational effectiveness). They are not there to provide the practice with the fish
 - vi. Coaches are there on a temporary not permanent assignment.
 1. Most in-practice assignments per Phase I (see below) will be for 1 year or less.
 2. Most in-practice assignments per Phase II (see below) will be for 3-6 months
 - vii. ROI:
 1. To practice: improved care, improved financials, improved work environment, improved staff participation, improved patient satisfaction, improved access to payer quality and performance incentives

2. To PO/PHO: higher producing, higher quality services to patients from member practices
 3. To patients: better health management, satisfaction, higher compliance, better coordination of care, more empowerment
 4. To employers: better quality of services, better health status, lower costs (direct and indirect)
 5. To community: better health status, lower costs
- b. Volunteer Process Improvement Coach System
- i. Volunteer coaches recruited thru ASQ Sections and divisions. ASQ National supports program.
 - ii. Regionalized with assistance of local partners, i.e. NBCH coalitions, Medical societies, etc.
 - iii. Partnering with NBCH for education, etc.
 - iv. Coaches screened and if chosen trained using Michigan model training curriculum and materials
 - v. Coaches committed for 4 hours per week (avg) and for one year
 - vi. Practices recruited must agree to commit resources and staff time for minimum of one year and report out data
 - vii. Coaches carefully screened and matched with practices
 - viii. Specific proven quality techniques like Cost of Current Quality (COCQ) will be used to illustrate value of process improvement to practice
 - ix. Coaches use MI process flow to mentor practices thru PDSA's in each of the areas of need identified by the practice
 - x. Several communities piloting and/or considering this model
 1. York, PA, Erie, PA are piloting it
 2. Akron, OH, Findlay, OH, Cincinnati, OH considering it thru coalitions and/or corporations
 3. Wisconsin considering it thru Wisconsin Medical Society