Exploring Population Health in the Triple Aim

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NRHI Webinar Presentation by
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Clinical Story

85-year-old male with a history of chronic heart failure, diabetes, depression, early stage dementia, hypertension, and COPD, who has been hospitalized three times earlier in the year....
Targeting the Triple Aim*

• Improve patient experience of care, including quality

• Improve population health

• Improve affordability by decreasing per capita costs

New Imperative

Perspective

What Business Are We In? The Emergence of Health as the Business of Health Care

David A. Asch, M.D., M.B.A., and Kevin G. Volpp, M.D., Ph.D.
What Makes Us Healthy

Population Health

- Physical Environment
  - Environmental quality
  - Built environment
- Socio-Economic Factors
  - Education
  - Employment
  - Income
  - Family/social support
  - Community safety
- Health Care
  - Access to care
  - Quality of care
- Health Behaviors
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex

Source: Authors’ analysis and adaption from the University of Wisconsin
Building Accountable Health Communities for Accountable Care

White Paper on Global Health Measures Used in MN Clinical Care

https://www.icsi.org/_asset/cwd6c8/measuringpophealth.pdf
# MN Community Measurement Framework 3-5 Year Vision

<table>
<thead>
<tr>
<th>MEASUREMENT FRAMEWORK AIM</th>
<th>CATEGORY</th>
<th>MNCM CURRENT CLINIC/AMBULATORY MEASURES</th>
<th>Opportunity 3-5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care</td>
<td>Patient experience/engagement</td>
<td>1. CG CAHPS</td>
<td>Patient activation Shared decision making</td>
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<td></td>
<td>Safety</td>
<td>1. ASC/hospital transfer/admission 2. ASC appropriate surgical site hair removal 3. ASC Prophylactic antibiotic timing</td>
<td>Complications Dosing</td>
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<td>1. Health care home care coordination 2. HIT survey</td>
<td>Post Acute Care Advanced Directives</td>
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<td></td>
<td>1. C-Section rate 2. (In development-Colonoscopy surveillance and quality)</td>
<td>Overuse measures Specialty elective procedures Implementation</td>
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<tr>
<td>Cost</td>
<td>Total cost of care</td>
<td>1. In pilot TCOC with actual cost.</td>
<td>Cost by Episode of Care Additional Price disclosure</td>
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<td>Relative resource use (TCOC with standardized cost)</td>
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<td>Relative Resource Use</td>
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<td>Expenditures by type of care</td>
<td>Per unit cost for top common procedures</td>
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<td>Healthy behaviors</td>
<td>1. (Under development- tobacco use, obesity) 2. Tobacco use embedded in some disease specific measures</td>
<td>Global Health Measures</td>
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<td>Community health</td>
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<td>Social, Economic factors</td>
<td>1. Race, ethnicity, language</td>
<td>Income in risk adjustment</td>
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Trends in Minnesota Health Care Spending and Rate of Growth

Source: MDH Health Economics Program
Reframing Conversations
“Going Outside Our Four Walls to Solve Complex Problems”

• RWJF grant to ICSI for communications to healthcare audience(s) for starting a conversation about connecting with community resources

• Minimum four communications
  – The “why” in a print and video format with a discussion guide
  – Relationships - a table of stories and resources
  – Data sharing examples to build common ground
  – Getting “Boards on Board” with the Triple Aim and connecting with the community
Clinical Story

85-year-old male with a history of chronic heart failure, diabetes, depression, early stage dementia, hypertension, and COPD, who has been hospitalized three times earlier in the year....

• MN Day Services center two days per week
  ➢ Health monitoring, socializes and eats a nutritious meal
  ➢ Exercises twice a week at the YMCA.
• No subsequent hospitalizations.
• Increased strength and balance - -put his cane away - -new lease on life.
What are the possibilities to connect to the community to bridge to population health?

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“Achieving Accountability for Health and Health Care”