Exploring Population Health in the Triple Aim

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NRHI Webinar Presentation by

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ICSI Institute for Clinical Systems Improvement
Transforming health care, together

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

*The Triple Aim: Care, Health, And Cost. Berwick DM, Nolan TW and Whittington J., Health Affairs, May 2008, Vol. 27, No. 3, 759-769.

New Imperative

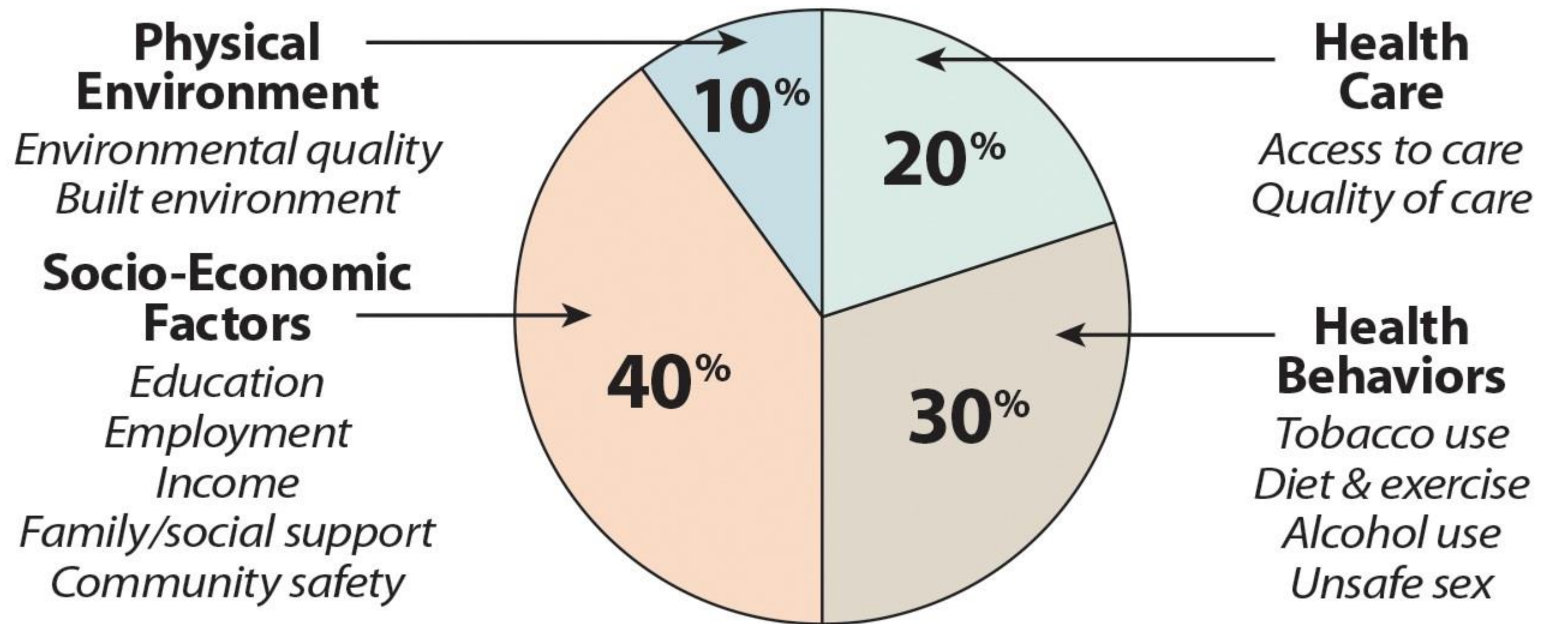
Perspective

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.

N Engl J Med 2012; 367:888-889 | September 6, 2012

What Makes Us Healthy



Source: Authors' analysis and adaption from the University of Wisconsin

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Building *Accountable Health Communities* for Accountable Care

Source: Magnan S, Fisher E, Kindig D, Isham G, Wood D, Eustis M, Backstrom C and Leitz S. Achieving Accountability for Health and Health Care. A White Paper Developed from the State Quality Improvement Institute 2008-2012 in Minnesota. Found at: http://bit.ly/V3Xvt0

White Paper on Global Health Measures Used in MN Clinical Care

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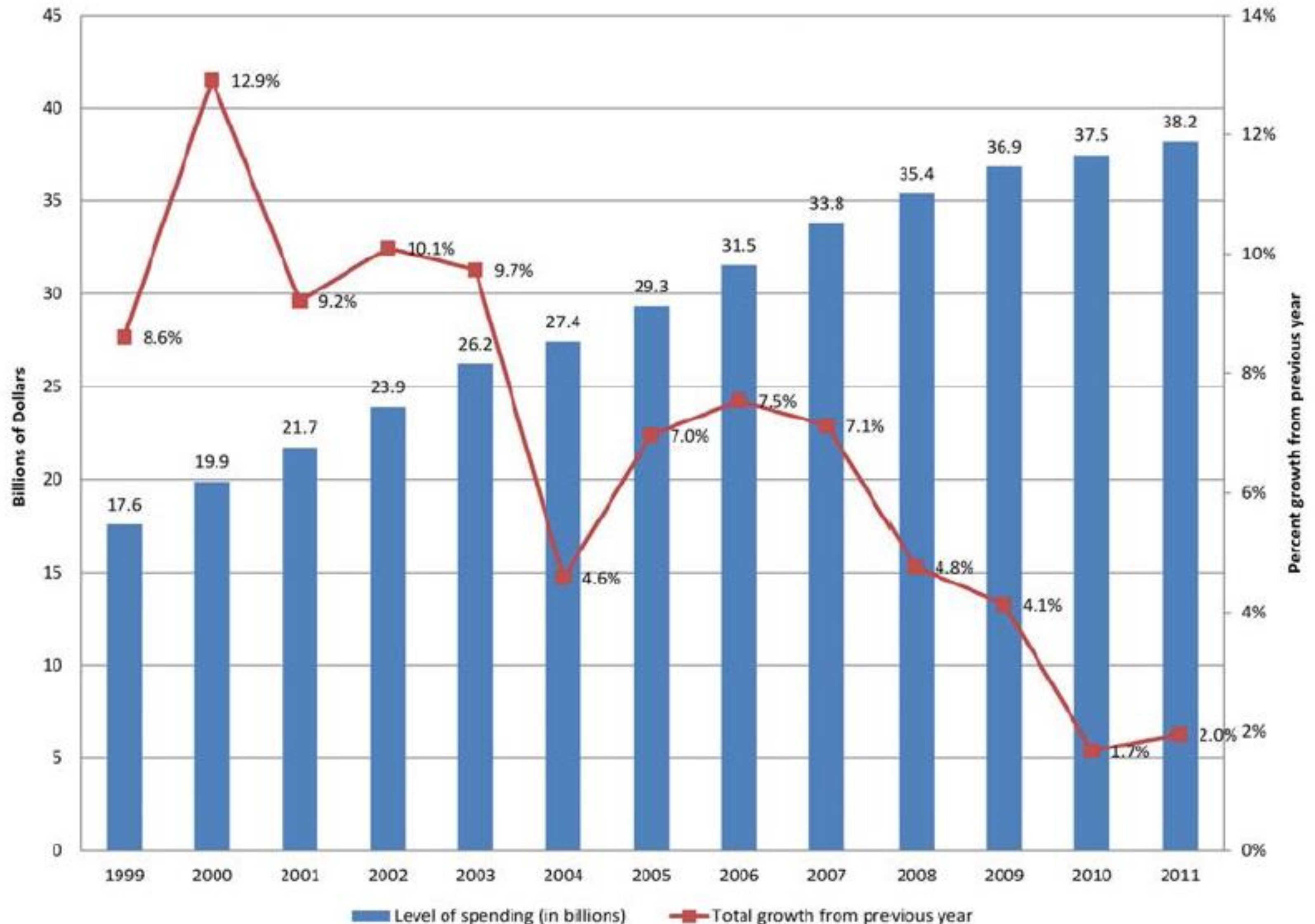
MEASURING HEALTH IN MINNESOTA:
IMPORTANCE, CHALLENGES AND FUTURE DIRECTIONS

https://www.icsi.org/_asset/cwd6c8/measuringpophealth.pdf

MN Community Measurement Framework 3-5 Year Vision

MEASUREMENT FRAMEWORK AIM	CATEGORY	MNCM CURRENT CLINIC/AMBULATORY MEASURES	Opportunity 3-5 years
Health Care	Patient experience/engagement	1. CG CAHPS	Patient activation Shared decision making
	Safety	1. ASC/hospital transfer/admission 2. ASC appropriate surgical site hair removal 3. ASC Prophylactic antibiotic timing	Complications Dosing
	Effectiveness, Quality, Outcome	**Process** 1. Controlling high blood pressure 2. Spirometry testing COPD 3. Depression use of PHQ9 4. Depression PHQ9 follow-up 6 and 12 months **Outcome** 1. Optimal vascular care 2. Optimal diabetes care 3. Optimal asthma care 4. Depression 6 month remission 5. Depression 12 month remission 6. Depression 6 and 12 month response 7. Total knee replacement 8. (In pilot Spine surgery)	Specialty Physician Other Clinician care Post Acute Care Patient Activation
	Coordination of care, timeliness, communication	1. Health care home care coordination 2. HIT survey	Post Acute Care Advanced Directives
	Appropriateness, Utilization, overuse, use of resources	1. C-Section rate 2. (In development-Colonoscopy surveillance and quality)	Overuse measures Specialty elective procedures
Cost	Total cost of care	1. In pilot TCOC with actual cost.	Implementation
	Relative resource use (TCOC with standardized cost)		Relative Resource Use
	Expenditures by type of care	Per unit cost for top common procedures	Cost by Episode of Care Additional Price disclosure
Individual and Community Population Health	Prevention	1. Breast cancer screening 2. Childhood immunization status 3. Cervical cancer screening 4. Colorectal cancer screening 5. Chlamydia cancer screening in women 6. Immunizations for adolescents 7. Pediatric preventive care	Retire high performing
	Healthy behaviors	1. (Under development- tobacco use, obesity) 2. Tobacco use embedded in some disease specific measures	Physical activity Risky substance use
	Community health		Global Health Measures
	Social, Economic factors	1. Race, ethnicity, language	Income in risk adjustment



Source: MDH Health Economics Program
http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2013.pdf

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.

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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"

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