The Triple Aim and College Health: Innovating Your Way to Better Care, Better Health, and Lower Costs

Carlo Ciotoli, M.D., M.P.A.
Associate Vice President of Student Health

Allison J Smith, M.P.A.
Manager of Public Health Initiatives and Assessment
Learning Objectives

• Define each dimension of the Triple Aim as a guiding framework for health system transformation.

• Discuss the unique challenges and opportunities with applying the Triple Aim framework to college health

• Discuss lessons and strategies from national and regional Triple Aim sites that can be applied to your own campus community
The *Triple Aim*

- Proposed by Berwick and Nolan in 2007 to re-envision healthcare around 3 core values
- What would it look like if health care were aligned to:

  - The *Triple Aim* requires the simultaneous pursuit of:
    - Improved health
    - Enhanced experience of care
    - Reduced cost per capita
Drivers of a Low-Value Health System

**Low Value**

- **High Cost**
  - New Drugs and Tech ≠ Outcomes
  - No mechanism to control cost at the population level
  - Supply-Driven Demand

- **Low Quality**
  - Over-Reliance On Doctors
  - Insignificant role for individuals and families
  - Under-valuing “system” design
YOU WANT TO SEE THE DOCTOR!? SURE ... HERE HE IS!
Triple Aim Initiative

• **Initial Prototyping (Sept ‘07 – April ‘08):**
  – 15 Organizations recruited to a Learning Institute
  – Integrated Delivery Systems, Health Plans, Safety Net Organizations, Self Insured Employers, State Agencies

• **What can you do** to accomplish these goals?
  – Define a **target population** that you can impact
  – What are you trying to accomplish for **all three aims**?
  – What **population oriented intervention** are you going to implement?
  – How will you **measure** impact?

• **Rapid growth to an international collaborative “learning system” of countries with technically advanced medical systems**
  – National, International Collaborative Meetings
  – Biweekly conference calls
  – Focused workgroups
North American Triple Aim Sites

**Health Plans**
- Blue Cross Blue Shield of Michigan (MI)
- Capital Health Plan (FL)
- CareOregon (OR)
- Essence Healthcare (MO)
- UPMC Health Plan (PA)
- Independent Health (NY)

**Integrated Delivery Systems (w/ Health Plans)**
- Caromont Health System (NC)
- HealthPartners (MN)
- Kaiser Permanente, Mid-Atlantic Region (MD)
- Martin’s Point Health Care (ME)
- Presbyterian Healthcare (NM)
- Southcentral Foundation and Alaska Native Medical Center (AK)
- Vanguard Health System
- Veterans Health System
- Wellstar Health System

**Integrated Delivery Systems (w/o Health Plans)**
- Allegiance Health (MI)
- Bellin Health (WI)
- Bon Secours - St. Francis Health System (SC)
- Cape Fear Valley (NC)
- Cascade Healthcare Community, Inc. (OR)
- Cincinnati Children’s Hospital Medical Center (OH)
- Erlanger Health System (TN)
- Fort Healthcare (WI)
- Genesys Health (MI) (Ascension)

**Safety Net**
- Colorado Access (CO)
- Contra Costa Health Services (CA)
- Health Improvement Partnership of Santa Cruz
- County (CA)
- Nassau Health Care Corporation (NY)
- North Colorado Health Alliance (CO)
- Primary Care Coalition Montgomery County (MD)
- Queens Health Network (NY)

**Employers/Businesses**
- QuadGraphics/QuadMed (WI)

**Canadian**
- Central East Local Health Integration Network
- Saskatchewan Ministry of Health
- British Columbia Team

**State Initiative**
- Vermont Blueprint for Health (VT)

Last Updated 12/1/09
Design of a Triple Aim Enterprise

- Define “Quality” from the perspective of an individual member of a defined population

- Individuals and Families
- Definition of “Primary Care”
- Integration
- Per Capita Cost Reduction
- Population Health Management

Institute for Healthcare Improvement, 2012
Principle 1
Involve Individuals and Families when Designing Care Models

• finding new ways to inform individuals and their families about the determinants of health and the benefits and limitations of health care practices and procedures
• working to change the “more is better” culture through transparency, education, and communication
• employing shared decision-making with patients and communities
Principle 2
Redesign “Primary Care” Services and Structures

• using teams to deliver basic services
• developing shared plans of care
• better cooperation and coordination with specialists, hospitals, and community resources related to health
• improving access through scheduling
Principle 3
Improve Population Health Management

• segmenting the population and deploying resources to high-risk individuals or other groups
• working with community on health promotion
• executing strategies to reduce variations in outcomes and variations in practice
Principle 4
Build a Cost-Control Platform

• assuring that payment and resource allocation support Triple Aim goals
• introducing yearly initiatives to reduce waste
• rewarding providers for their contribution to better health for the population
Principle 5
Support system integration and execution

• matching capacity and demand for social services across suppliers
• ensuring that strategic planning execution with all suppliers including hospitals and physician practices are informed by the needs of the population
• developing a system for ongoing learning and improvement
• customizing services based on the appropriate segmentation of the population
# Potential Triple Aim Outcome Measures

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Health</strong></td>
<td>1. Health/Functional Status: single-question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol)</td>
</tr>
<tr>
<td></td>
<td>2. Risk Status: composite health risk appraisal (HRA) score</td>
</tr>
<tr>
<td></td>
<td>3. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions; summary of predictive model scores</td>
</tr>
<tr>
<td></td>
<td>4. Mortality: life expectancy; years of potential life lost; standardized mortality rates</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>1. Standard questions from patient surveys, for example:</td>
</tr>
<tr>
<td></td>
<td>• Global questions from US CAHPS or How’s Your Health surveys</td>
</tr>
<tr>
<td></td>
<td>• Experience questions from NHS World Class Commissioning or CareQuality Commission</td>
</tr>
<tr>
<td></td>
<td>• Likelihood to recommend</td>
</tr>
<tr>
<td></td>
<td>2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)</td>
</tr>
<tr>
<td><strong>Per Capita Cost</strong></td>
<td>1. Total cost per member of the population per month</td>
</tr>
<tr>
<td></td>
<td>2. Hospital and ED utilization rate</td>
</tr>
</tbody>
</table>
Stages of Facing Reality

• “The data are wrong”
• “The data are right, but it’s not a problem”
• “The data are right; it is a problem; but it is not my problem.”
• “I accept the burden of improvement”
Triple Aim Model: Micro integrators
Can We Begin with the Individual and Scale Up?

- Act with the Individual and Family
- Learn for the Population

Design and Coordination of Care

Per Capita Cost  Population Health

Individual Experience
Needed: The “Integrator”

- It may or may not be a new structure or organization.
- It pulls together the resources to support a defined population.
- It builds alliances and coalitions.
- It optimizes the Triple Aim for the sake of a defined population.
- It works with and helps to improve micro-systems to support individuals.
Initial Triple Aim “Macro-Integrators”

- **Hospital-Based Systems**
  - Cincinnati Children’s Hospital Medical Center (OH)
  - Bellin Health (WI)
  - Genesys Health (MI) (Ascension)
- **Integrated Health Systems**
  - Group Health (WA)
  - HealthPartners (MN)
- **Health Plans**
  - CareOregon (OR)
  - New York-Presbyterian System SelectHealth, LLC (NY)
- **State Initiative**
  - Vermont Blueprint for Health (VT)
- **Safety Net**
  - CareSouth Carolina (SC)
  - Contra Costa Health Services (CA)
  - North Colorado Health Alliance (CO)
  - Primary Care Coalition Montgomery County (MD)
  - Queens Health Network (NY)
- **International**
  - Jönköping (Sweden)
  - Bolton Primary Care Trust (England)
Early Triple Aim Examples

• Vermont Blue Print for Health: All Payer Community Health Teams
• Jonkoping County Council: Health System – School System Collaboration to reduce childhood obesity
• Common Ground: Proactive outreach to high risk homeless population
• Health Partners: Integrated Medical System/ health plan focused on high quality, cost effective care
HealthPartners

• Based in Bloomington, MN
• Largest consumer governed, nonprofit HCO in US (integrated system)
• Their Triple Aim focus was on chronic disease (specifically diabetes)
• Focused on reliability
HealthPartners

• Recognized a broken system-a NON System
• Reliability and Standardization
• Use of the Chronic Care Model
• Use of measurement: 5 targets for diabetes
HealthPartners

• Patients who achieved all 5 targets
  – HgB A1C $\leq 7.9$
  – LDL $\leq 99$
  – Blood pressure $\leq 139/89$
  – Non-tobacco user
  – Regular ASA use

• Results: went from 5% to 65% of all DM hitting ALL 5 targets
## Simple Rules for the 21st Century Health Care System

<table>
<thead>
<tr>
<th>Current Approach</th>
<th>New Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is based primarily on visits.</td>
<td>Care is based on continuous healing relationships.</td>
</tr>
<tr>
<td>Professional autonomy drives variability.</td>
<td>Care is customized according to patient needs and values.</td>
</tr>
<tr>
<td>Professionals control care.</td>
<td>The patient is the source of control.</td>
</tr>
<tr>
<td>Information is a record.</td>
<td>Knowledge is shared and information flows freely.</td>
</tr>
<tr>
<td>Decision making is based on training and experience.</td>
<td>Decision making is evidence based.</td>
</tr>
<tr>
<td>Do no harm is an individual responsibility.</td>
<td>Safety is a system property.</td>
</tr>
<tr>
<td>Secrecy is necessary.</td>
<td>Transparency is necessary.</td>
</tr>
<tr>
<td>The system reacts to needs.</td>
<td>Needs are anticipated.</td>
</tr>
<tr>
<td>Cost reduction is sought.</td>
<td>Waste is continuously decreased.</td>
</tr>
<tr>
<td>Preference is given to professional roles over the system.</td>
<td>Cooperation among clinicians is a priority.</td>
</tr>
</tbody>
</table>
“We’re ready to begin the next phase of keeping things exactly the way they are.”
Keys to Doing This Work

- A clear vision
- A Triple Aim focus
- The right leadership structure
- Design principles
- Cultural change
- Involvement of patients and families
- Teamwork
CareOregon = Starting with the Costliest Members

10% Savings Has $12MM Annual Impact On CareOregon

<table>
<thead>
<tr>
<th></th>
<th>% of Members</th>
<th>% of Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Users</td>
<td>23%</td>
<td>1%</td>
</tr>
<tr>
<td>Healthy Users</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Low</td>
<td>24%</td>
<td>8%</td>
</tr>
<tr>
<td>Mod</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>High</td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>Very High</td>
<td>3%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Bus Pass $23 versus ED $1400

- “Member was seen in the ED 21 times in Dec. 2007.”
- “History of heroin use, transportation barriers to receiving Methadone treatment and from seeing her PCP on a regular basis.”
- “We bought a bus pass.”
- “No ED visits for two months and she is much more engaged in CD treatment and her PCP relationship.”
Triple Aim as Social Movement

• Triple Aim is now an international movement of 60+ organizations engaged in health system redesign
  – All from countries with a high levels of medical technology -- recognize that science / technology itself does not deliver health outcomes
  – All with different delivery systems... and outcomes...

• Creating our “best possible health...”
  • **How** care is delivered is a major determinant of health, experience, cost, at every level from the bottom up...
  • **What** is delivered must include much more than medical therapies, addressing social determinants as well...
  • **Who** drives change critically determines how effectively any system truly meets the wants and needs of those it is meant to serve.
Set direction: mission, vision and strategy

Push
Make the status quo uncomfortable

Make the future attractive

Pull

Build will
- Plan for innovation
- Set aims and allocate resources
- Measure system performance
- Provide encouragement
- Make financial linkages
- Learn subject matter
- Work on the larger system

Generate ideas
- Read and scan widely; learn from other industries and disciplines
- Benchmark to find ideas
- Listen to customers
- Invest in research and development
- Manage knowledge
- Understand organization as a system

Execute change
- Use model of innovation for design and redesign
- Review and guide key initiatives
- Spread ideas
- Communicate results
- Sustain improved levels of performance

Establish the foundation
- Reframe operating values
- Develop innovation capability
- Prepare personally
- Choose and align the senior team
- Build relationships
- Develop future leaders

New Mental Models: Transitioning from Volume-to-Value-based Systems

**Volume**
- Patient Satisfaction
- Increase Top-Line Revenue
- Complex All-Purpose Hospitals and Facilities
- Quality Departments and Experts

**Value**
- Persons as Partners in Their Care
- Continuously Decrease Per Unit Cost and Waste
- Lower Cost, Focused Care Delivery Sites
- Quality Improvement in Daily Work for All Staff
High-Impact Leadership Behaviors

1. **Person-centeredness**
   Be consistently person-centered in word and deed

2. **Front Line Engagement**
   Be a regular authentic presence at the front line and a visible champion of improvement

3. **Relentless Focus**
   Remain focused on the vision and strategy

4. **Transparency**
   Require transparency about results, progress, aims, and defects

5. **Boundarilessness**
   Encourage and practice systems thinking and collaboration across boundaries
IHI High-Impact Leadership Framework with Examples

- **Driven by Persons and Community**
  - Include patients on improvement teams
  - Start meetings with patient stories and experience data
  - Use leadership rounds to model engagement with patients and families

- **Develop Capability**
  - Teach basic improvement at all levels
  - Invest in needed infrastructure and resources
  - Integrate improvement with daily work at all levels

- **Shape Culture**
  - Communicate and model desired behaviors
  - Target leadership systems and organizational policies with desired culture
  - Take swift and consistent actions against undesired behaviors

- **Create Vision and Build Will**
  - Boards adopt and review system-level aims, measures, and results
  - Channel leadership attention to priority efforts
  - Transparently discuss measures and results

- **Deliver Results**
  - Use proven methods and tools
  - Frequently and systematically review efforts and results
  - Devote resources and skilled leaders to high-priority initiatives

- **Engage Across Boundaries**
  - Model and encourage systems thinking
  - Partner with other providers and community organizations in the redesign of care
  - Develop cross-setting care review and coordination processes
“Oh, if only it were so simple.”
Small Group Exercise

1. Design an optimized college health delivery model focused on a specific pre-determined topic while taking into account ALL three Triple Aim dimensions:
   – improving the health of your group’s defined population
   – enhancing the patient care experience (including quality, access and reliability)
   – reducing, or at least, controlling the per capita cost of care

2. Apply the five Triple Aim design components to college health and specific to your group’s focus