TRIPLE AIM LEARNING: CORE CONCEPTS
A System design that is one aim with three dimensions:

- Improving the health of the populations;
- Improving the patient experience of care;
- Reducing the per capita cost of health care.
Enrolled Populations: Triple Aim for a defined population that makes business sense (e.g. who pays, who provides)

Community-Wide Populations: Solving a health problem within the community and creating a sustainable funding source
The Growth and Evolution toward Population Health

Key Points of Discussion

• Population Medicine or Population Health is not a singular choice – they sit on a continuum and you will have a mix in your portfolio at the same time

• The shift toward Population Health is more of an evolution than a revolution

• It will be important to manage the total CCHMC portfolio to build accountability, engagement, momentum, funding and scale

Population Health

• Expanded set of activities related to the medical care system
• Still a focused population defined by clinical condition
• Less direct control and centralized accountability
• Can have direct ROI to the hospital or practice
• Example: CCO

Population Medicine

• Specific activities of the medical care system
• Focused on clinical care for the individual patient most often to resolve illness
• Most direct control and centralized accountability
• Most direct ROI to the hospital or practice
• Example: Urgent Care visit

Clinical Care Delivery/Medicine

• Full set of activities aimed at improving health outcomes for a large population
• Requires active consideration of non-clinical determinants of health
• Partnership and shared accountability are important
• Complex ROI calculation
• Example: Infant Mortality
Foundational Setup for Population Management

1. **Choose a relevant Population** for improved health, care and lowered cost.

2. **Identify and develop the Leadership and Governance** for your effort.

3. **Articulate a Purpose** that will hold your stakeholders together.
Managing Services at Scale

- Identify a population segment on which to focus.
- Conduct a needs and assets assessment
- Develop a portfolio (group) of projects that will yield Triple Aim results
- Design or redesign services to meet the needs of the population
- Develop a plan for delivery of services at scale
- Expand the capabilities of “integrator” organizations
Managing Services for a Population

Community, Family and Individual Resources

- Needs Assessment for Segment
- Service Design
- Delivery of Services at Scale

Population Segmentation → Needs Assessment for Segment → Goals → Coordination → Delivery of Services at Scale → Population Outcomes

Integrator

Feedback Loops
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<th>Initiative</th>
<th>Sample Projects</th>
<th>Investments</th>
<th>Capabilities</th>
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<td>Practice Coaching Certification</td>
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<td>Development and testing Staffing and training</td>
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<td>Care Transitions</td>
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<td>Testing, scale up and spread</td>
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<td>Safety</td>
<td>High reliability training Safety event tracking and reporting Daily Leadership Huddles</td>
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<td>Community Engagement</td>
<td>Safe Routes Healthy Schools Advanced Care Planning</td>
<td>Time Partnerships</td>
<td>Community collaboration Population perspective</td>
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<td>IT transformation</td>
<td>IT and process transformations EMR, Registry, RHIE</td>
<td>Staff and tools</td>
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<td>Aligned Payment Systems</td>
<td>Pioneer ACO Bundled Payment Opportunities PCMH Incentives Partnerships with commercial payers</td>
<td>Leadership commitment Relationship building Development and testing Scale up and spread</td>
<td>Cutting edge knowledge Risk taking Relationship building Rapid redesign Flexibility</td>
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### Managing Populations: Example of A Portfolio of Projects & Investments

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Learning System for Population Management

1. System level measures
2. Explicit theory or rationale for system changes
3. Learn by testing: PDSA cycles, sequential testing of changes, Shewhart time series charts
4. Use informative cases: “Act for the individual learn for the population”
5. Learning during scale-up and spread with a production plan to go to scale
6. People to manage and oversee the learning system
## Potential Triple Aim Population Outcome Measures

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<th>Dimension</th>
<th>Measure</th>
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| **Population Health** | 1. Health Outcomes:  
  - Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates  
  - Health/Functional Status: single question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12)  
  - Healthy Life Expectancy (HLE): combines life expectancy and health status into a single measure, reflecting remaining years of life in good health  
  2. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions  
  3. Risk Status: Behavioral risk factors include smoking, alcohol, physical activity, and diet. Physiological risk factors include blood pressure, BMI, cholesterol, and blood glucose. (possible measure: a composite Health Risk Appraisal (HRA) score) |
| **Experience of Care** | 1. Standard questions from patient surveys, for example:  
  - Global questions from US CAHPS or How’s Your Health surveys  
  - Experience questions from NHS World Class Commissioning or CareQuality Commission  
  - Likelihood to recommend  
  2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered) |
| **Per Capita Cost** | 1. Total cost per member of the population per month  
  2. Hospital and ED utilization rate and/or cost |
Learning System for Population Management

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TRIPLE AIM LEARNING: ENROLLED POPULATIONS
Challenges for Working with an Enrolled Population

- Good understanding for treating disease not managing populations
- Financial model supports the care of disease and not populations
- Even for defined populations there is a need to work on the upstream determinants of health which is new for health care
What is your business model for population health? How will you manage the transition from fee for service to population management without financially damaging your organization?

How do you engage physicians and how will they work in different kinds of relationships than we had before? How will you engage primary care doctors in this work in general? New payment models for primary care? Decreasing clinical variation?

How will you redefine quality, safety, and productivity from a population management perspective (health, experience, value)? What will your goals/aims be for this?
Moving Toward Population Management

- What skills and people do you need to manage the transition? Do you have enough capacity and capability to manage a population-based portfolio? How will you equip your leaders to manage and support this transition? Will you reward system change?

- How are you going to engage patients and community in the future? Their activation will be key to holding down costs.
Beware of the “Triple Aim Side Show” – The Triple Aim and population management needs to be strategic, not just one of many “projects.”

Choose a population which makes sense for the Triple Aim, with a business model to support it.

Create a clear “why” statement - something that can hold a group together during challenging times.

Choose a portfolio of projects that matches your goals (beware of an underwhelming portfolio!).

Identify what full scale looks like for you.

Don’t rely too much on planning. Test your way through it.
TRIPLE AIM LEARNING: COMMUNITY-WIDE POPULATIONS
Challenges for Working in a Region

- Cooperating among competitors without violating anti-trust regulations.
- Establishing regional governance structures that are sustainable.
- Integrating health care with public health and social services.
- Involving businesses and unions in the effort.
- Developing business models and transition strategies.
Community Collaboration for Population Health

- Discuss and observe who is at the “table”, who is not and why? Who needs to be there? And who is optional for this work?
- What is the burning platform for this work?
- Who is committed to making it work? Who is neutral? Who is skeptical? Who wants it to fail?
- Is there a commitment to transparent regional measurement for all aspect of the Triple Aim?
- How will you work on the multiple determinants of health for this population?
- Can health care also play a significant role in improving the health of this population?
- How will you address health equity issues?
Triple Aim Learning from Communities

- Draw upon existing governance structures within your organization or community.
- It’s in the telling of “war stories” that builds the will and confidence across sectors, not always in “best practice.”
- Focus on assessing community strengths and capacity over “needs.”
- Honor your partners but don't wait for consensus: If a region waits for all stakeholders to cooperate they will never start. “Leave the door open.”
- Let’s get real about self interest.
- Health Care as a Second Language “HCSL”
- “You have one mouth and two ears, use them proportionally”
- Decisions are made by the those who show up.
- Assume that you will need to lose a bit of control for much, much more power.
For Discussion:
Think of the population you serve…

If your population is **enrolled**:

1. How will working with this population work in your present business model?
2. What business skills do you hope to gain by working with this population?
3. What skills and people do you need to manage the transition?
4. How are you going to engage patients and community in the future?

If your population is **geographic**:

1. What is the burning platform for this work?
2. How will you work on the multiple determinants of health for this population?
3. Can health care also play a significant role in improving the health of this population?
4. How will you address health equity issues?
Thank you for joining us!