D4 / E4
Pursuing the Triple Aim:
Seven Innovators Show the Way to
Better Care, Better Health, and Lower Costs

24th Annual National Forum on Quality Improvement in Health Care
Orlando, FL

Maureen Bisognano
Charles Kenney

Who’s With Us Today

- Beth Waterman, HealthPartners
- Rob Janett, Mount Auburn Cambridge Independent Practice Association (MACIPA)
- Mindy Stadtlander, CareOregon
- Diane Miller, Virginia Mason Institute
- Alide Chase, Kaiser Permanente
The IHI Triple Aim

- An ambitious aim for health care leaders
  - Reflects societal needs and responds to urgent needs for attention to all three dimensions

Health of a Population

- We’re spending $2.7 trillion per year on health care in the US
- 75% of this on chronic disease management in the US, with similar allocations in other countries
- All metrics of chronic disease are heading in the wrong direction
Experience of Care

- We've seen improvements in safety and access, but the gaps we still have to close are clear
- Patient-centeredness is still in infancy and moving to “What matters to you?” will exhilarate and challenge
- Equity remains a problem in the US and other countries
- The lack of coordination, even in national health systems, presents a major opportunity

Per Capita Costs

- Cost trends in the US are still unsustainable
- Other nations face tremendous cost pressures as well
Pursuing the Triple Aim

- So, we set out to find the leaders who were forging ahead, before the mandate or the business case
- We visited many amazing places and chose these as widely representative:
  - HealthPartners
  - Virginia Mason Medical Center
  - CareOregon
  - Mt. Auburn Hospital / MACIPA
  - Bellin Health
  - UPMC
  - Kaiser Permanente

What We Found

- The differences were greater than the similarities, except in these areas:
  - Visionary and courageous leaders
  - Commitment and dedication to a population (“I know them…”)
  - Financial stability or time to build a bridge to a new model
  - Improvement capability
  - Incredible patient-centeredness
We Want You to Hear from Them

- So...
  - 6 slides > 6 minutes
  - Deep conversations and planning for your return home
  - Resources and connections to support your work

The Triple Aim at HealthPartners

IHI Forum
December 12, 2012

Beth Waterman
Chief Improvement Officer
HealthPartners
Triple Aim Results

- Strong results across multiple measures
  - Highest performing medical group on Minnesota Community Measurement, 13/15 measures fully above average
- 99% of patients would recommend us
- Total cost of care ~10% below the statewide average
  - Potential to save $2 trillion over the next decade if our best practices are spread across the nation (IHI)
Elements needed for Triple Aim Results

- Culture aligned with the Triple Aim
- A system that can reliably produce results using design principles of:
  - Reliable processes to deliver evidence-based care
  - Customizing care to individual patient preferences, values and unique characteristics
  - Access that’s easy, convenient and affordable
  - Coordination across all points of care, conditions and time

Better Health for Patients with Diabetes

- 364 fewer heart attacks
- 68 avoided leg amputations
- 625 prevented eye complications
- 1,200 fewer visits to the ER
- $18,500 saved for patients with optimally managed diabetes (numbers per year)

Measure: the % of patients whose diabetes is well controlled:
- Blood pressure under control (≤ 139/89)
- Healthy cholesterol (≤ 99)
- Blood sugar under control (A1c ≤ 7.9)
- Non-smoker
- Regular aspirin user
Diabetes - 14,467 eligible patients
25% of State Program patients have BH diagnosis
18% of State Program patients have Opioid script
2000 frail & elderly that have an avg of 16 scripts
1% of patients = 25% costs

Patient-Centered Care

- Proactively identify patients with current or potential needs
- Reach out to patients who need to come in for a visit, or need support between visits
- Every member of the care team has a role
- Decision supports in the electronic health record
- Care is customized for patients from diverse backgrounds and cultures
- Provide easy and convenient access to care
- Care provided anywhere in the system
Pursuing the Triple Aim: The Alternative Quality Contract

Mount Auburn Cambridge Independent Practice Association

Rob Janett
Medical Director

Agenda

• MACIPA
• The Alternative Quality Contract (AQC)
• Managing a Multitude of Metrics
• Patient Experience
• Results
MACIPA

• ~500 physicians with ~70,000 covered lives
• Cambridge and surrounding towns
• Strategic alliance with private (Mt Auburn) and public (Cambridge) hospitals
• The first letter in IPA is “I”
• Working toward shared vision of quality and patient experience over a 25 year history

The Alternative Quality Contract (AQC)

• Blue Cross Blue Shield of Massachusetts
• Avoids the common pitfalls of capitation and P4P by combining the incentives of both payment schemes
• 32 quality metrics span the full spectrum of care: acute, chronic disease, prevention, patient experience
• Rewards efficiency
• Five year term: “Hold the gains!”
Patient Experience

• How to influence a disparate network of private and hospital owned practices?
• Consultant. Tools. Incentives.
• Office staff are key to success
MACIPA is Improving Ambulatory Quality in the AQC

For preventive care, MACIPA-Mount Auburn’s performance improved each year of the contract to date.

MACIPA-Mount Auburn also improved patient experience scores over the course of the AQC, increasing from a score of 2.7 in 2007 to 3.0 in 2011.

Hospital Performance in AQC: Mount Auburn Providing Efficient and High Quality Care

Quality: Mt Auburn showed nearly-perfect performance on inpatient clinical process measures (2009, 2010, 2011) and significant improvement on clinical outcome measures.

Resource Use: In 2011, MACIPA/Mt. Auburn have sustained lower-than-network use of hospital for non-urgent ED visits and ambulatory care sensitive admissions.
- Non-urgent use of ED: Rates are about 7% lower than Network Average
- Ambulatory sensitive admissions: Rates are 17% lower than Network Average
Triple Aim Population Scale-up:
Moving From a Subpopulation to an Enterprise Population

“Primary Care Renewal to Patient, Population Centered Primary Care
Transforming our Primary Care Delivery Network

CareOregon

Our Vision: Healthy Oregonians regardless of their income or social circumstances.

- State Funded Health Plan for “vulnerable” citizens
  - Medicaid: Women and Children, Disabled/Chronically Ill
  - Medicaid/Medicare “Special Needs” Plan
- Transitioning into Coordinated Care Organization in 5 regions in Oregon
- 164,000 Members
- Current Contracted network
  - 50% Safety Net CHCs
  - Diverse Private Primary Care Practices
  - Major metro and rural hospitals
- Initial Participant in IHI Triple Aim
Building A Primary Care “Medical Home” Learning Collaborative

• 2007: Charter Meeting: Agree on Vision and Core Principles
  – Freedom to explore how principles implemented based on context.
• “Step into the work” collectively:
  – Breakthrough Series Collaborative with “Pilot” care teams
  – Create “emergent” new knowledge through practice
• Establish a learning system
  – Lead with principles, follow with tools and measures
    • Emphasis on high yield change methods
      – Model for Improvement/ PDSA cycles / Lean
    – Transformation as “culture change”

SPREAD -- Primary Care Renewal
New Development:
Patient and Population Centered Primary Care (PC³)

- Learned from the Primary Care Renewal Collaborative
- Wanted to spread the best practices they discovered
- Medical Home tools and techniques combined with process improvement skills

**Focus on the practical tools!**

Virginia Garcia: Wellness Center
Complete New Practice Design
New Development:
Enhancing the Health Home Team with Community Outreach Capability

Community outreach workers are paired with primary health homes and specialty practices to enhance the practices’ ability to provide individualized ‘high touch’ support to patients with exceptional utilization

- Staff are hired for engagement skills, compassion, non-judgmental attitude, outreach experience
- Focus is on the social determinants that drive high-cost medical utilization
- Voluntary program
- High PCP/Specialist involvement
- Outreach worker is incorporated as part of the practice team, but also has identity with a larger community of practice
- Documentation occurs in the practice’s EMR; population view and process metrics stored in a community care registry

Marketplace Collaboratives for Better, Faster, More Affordable Care

Diane K Miller, Executive Director  Virginia Mason Institute
**A Marketplace Collaborative**

1. **Employer** uses purchasing power to define products and quality specifications.

2. **Provider** produces product to quality specs.

3. **Health plan** pays for delivery of quality specs.

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**Employer Defines Products**

**Doing the Right Thing: High Cost Conditions**

1. Screening and prevention
2. Back pain
3. Shoulder, knee and hip pain
4. Headache
5. Respiratory symptoms
6. Breast symptoms
7. Depression
8. Diabetes
9. Abdominal pain
10. Chest pain

*High volume, low per-capita cost conditions*
**Employer Defines Quality Specs**

**Doing Things Right**

**Better**
1. Evidence-based care: what works
2. 100% patient satisfaction

**Faster**
3. Same-day access
4. Rapid return to function

**More Affordable**
5. Affordable price for employer and provider

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**Value Stream Mapping**

**Right Process: Patient Perspective for Back Pain**

- PCP → PCP → MRI → PCP → Neurosurg → Physiatry → PT visits (1-15)

- TIME

- □ Waits and delays
- □ Non value-added
- □ Evidence-based value

Waiting has indirect cost to employer of over $18/hr
Value Stream Mapping
Right Process: Care of Back Pain Redesigned

Wait for appt
Spine Clinic
PT: 2.8 visits

- Waits and delays
- Non value-added
- Evidence-based value

TIME

Waiting has indirect cost to employer of over $18/hr

Evidence-Based Imaging
Mistake-Proofing

MRI Back Exam
Exam Requested
- mr spine
- mr spine w/ w/o contrast
- mr spine w/ w/o contrast
- mr spine w/ w/o contrast

Current Weight
60 kg
260 lb

Indications (select all that apply)
- motor deficit (785.99)
- Unremitting pain despite 6 weeks of appropriate therapy
- Document in relevant history field and apply appropriate ICD 9 code
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- Document in relevant history field and apply appropriate ICD 9 code
- Consult has been performed by physical medicine.

NOTES: If spine MRI will likely not be helpful for the patient with back or neck pain if none of these indications are present. The Spine Clinic physician on call will provide help by phone and offer a same day visit to assist in care of the patient. Phone (spine clinic page number) on VSP and enter the following message: "Dr. --- wishes to speak with you about a patient with neck/back pain in whom an MRI is not indicated. Please call (page number of ordering provider)."
Evidence-Based Imaging

Results: Mistake-proofing

- Headache: -23%
- Low back pain: -23%
- Sinusitis: -27%

Mistake-proofing Implemented

Reduction in imaging

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<th>Head MR</th>
<th>Sinus CT</th>
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Quality Specs Drive Results

Better, Faster and More Affordable

For patients
- 98% satisfaction
- 50% less work loss

For employers
- 23% less imaging
- 50% less physical therapy
- 50% less absenteeism

For providers
- 50% increase in margin

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A KP Example: Total Health

Alide Chase
SVP, Medicare Clinical Operations and Population Care

December, 12, 2012
Acknowledging the work of Lisa Schilling, Trina Histon, Members of the Total Health Committee

Our vision is to be a leader in Total Health by Making Lives Better

Total Health is…
Clinical * Behavioral * Environmental * community strategies
... for improved health including equitable and affordable care

Many factors drive and shape health
Drivers of Health

Health is driven by multiple factors that are intricately linked – of which medical care is one component. Total Health is a comprehensive solution that addresses all components
The “Total Health” Framework

Bringing together our mission, brand, knowledge and capabilities:

Deploying Kaiser Permanente Assets for Total Health

Physical and Mental Health Care
“Body, Mind and Spirit”

Clinical Prevention
Research and Technology
Community Health Initiatives
Environmental Stewardship
Public Information

Individual / Family

Home / School / Worksite

Neighborhood / Community

Society

Access to Social and Economical Supports
Worksite/Workforce Wellness
Public Policy

Total Health Portfolio

Total Health will require a coordinated set of activities, focusing on some key initial areas while developing core capabilities and enhancing efforts on work underway.

Total Health Focus Areas
Focus as first and relatively complete demonstrations of Total Health, done everywhere in KP

Healthy Schools
Healthy Workforce

Core Capabilities “Fundamentals”
Essential components needed to realize Total Health

Effective strategies for behavior change, inside and outside care delivery system (eating, activity, smoking, alcohol)
Member Assistance Program for social services (referral and eligibility solution)
Effective communications
Integrated model (care, connectivity, data, incentives)

Applications of Total Health
Work underway but Total Health lens can help deepen the work and re-double our efforts

KP Walk/Every Body Walk
HEAL/obesity prevention and treatment (OPT)
Hypertension control
Disparities elimination
Obesity Prevention and Treatment in Care Delivery

1. Assessment/Planning
   Building a Foundation across the Lifespan
   - Everyone – Entire Lifespan
     - Implement EVS, track BMI
   - Healthy Beginnings (0-5)
     - Breastfeeding in hospitals
     - Determine opportunity to spread SCAL prenatal POE
   - School Age (5-17)
     - Healthy Schools – healthy eating, active living

2. Early Implementation
   Testing New Interventions
   - Identify risk factors
   - Test referral resources: person, online, community
   - Map breastfeeding beyond hospital
   - Map Ob/GYN to pediatrics handoff
   - Community interventions
   - Prenatal POE
   - Test campaigns focused on age-appropriate strategies

3. Implementation and Scale
   Understanding and Amplifying Successes
   - Implement effective interventions
   - Link outcomes into KPHC registry/panel management
   - Evaluate member engagement, population outcomes
   - Evaluate effectiveness of early breastfeeding, community interactions, Ob/Gyn to pediatrics handoff
   - Measure impact of age-appropriate strategies

Core Elements
Measurement and Evaluation
Guideline Development
Evidence-based Support Systems

Key Elements

Why Behavior Change Now?
KP diabetes burden to surge over time

Pre-diabetes
2012
1.67 million
52% develop diabetes over 10 years

KP members with type 2 DM in 2012
477,383
$3.48 B/year

New cases of diabetes by 2022
868,400
$6.3 B/year

1 – Preliminary data, CMI Analysis October 2012; Pre-diabetes defined according to ADA definition using lab values
2 – Diabetes Prevention Research Group, Diabetes Prevention Program
3 – Preliminary data, CMI Analysis, as of March 31 2012; CORE KP HEDIS Diabetes cohort, minus expected % of Type 1 diabetes per CDC national prevalence
4 – Based on average annual medical expenditure estimates, Vojta et al, Hlth Aff, Jan 2012. Effective Interventions for Stemsing Diabetes and Pre-Diabetes
Framing of a Comprehensive Strategy for Behavior Change

- **Clinical execution**, including reliable delivery of the 5-As and support resources (e.g., Health coaching, community classes)

- **Online engagement** including optimal use and evolution of kp.org (i.e., MyHealthyLife), mobile apps, etc.

- **Healthy workplace** strategies leveraging KP’s Workforce Wellness initiatives and employer-facing assets and strategies

- **Environmental and community** strategies to support health choices

Next steps in Behavior Change at KP

- Pursue changes in wellness support offerings based on science
- Leverage the wellness coach as the 1-800 contact for exercise and nutrition lifestyle change
- Embed behavior change science in EVS and pre-diabetes work
- Leverage THA and kp.org assets
- Convene a behavior change network across regions
- CME for providers about behavior change skills
Resources


- *Are You Ready to Pursue the Triple Aim?* (online readiness assessment tool)
  - [http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/TripleAimReady.aspx](http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/TripleAimReady.aspx)

Thank You!

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