Beyond the Walls: Triple Aim Collaborations with Community Leaders

- Presenters: Ros Gray, Matt Guy, Jennifer Bennet, Stacy Kramer
- Facilitator: Niñon Lewis

Rapid Fire Presenters

- Ros Gray, Director
  Scottish Early Years Collaborative
- Matt Guy, Managing Director
  Pueblo Triple Aim Coalition
- Jennifer Bennet, Executive Director
  The Family Van
- Stacy Kramer, Project Manager
  Cincinnati Children’s Hospital Medical Center

Facilitator: Niñon Lewis, Director, IHI Triple Aim Initiatives
Session Objectives

- Learn about community organizing and collaboration approaches to generate public health interventions
- Understand governance and collaboration structures that will guide Triple Aim efforts
- Draw lessons and strategies from the field on achieving collective impact through interdisciplinary and interagency partnerships that can be applied to your own organization or community.

PURSUITING THE TRIPLE AIM IN A REGION OR COMMUNITY
Definition

IHI Triple Aim

- System designs that simultaneously improve three dimensions:
  - Improving the health of the populations;
  - Improving the patient experience of care (including quality and satisfaction); and
  - Reducing the per capita cost of health care.

Design of a Triple Aim Health System Enterprise
Getting Started on the Triple Aim

**Aim:** Apply the Triple Aim to a population served by your organization or a population of interest in your region.

- Choose a relevant *Population* for improved health, care and lowered cost
- Articulate a *Purpose* that will hold your stakeholders together
- Choose *Measures* that will show improvement for the population
- Develop a *Portfolio* (group) of projects that will yield Triple Aim results
  - No individual project can accomplish the Triple Aim but a portfolio of projects that are executed well can move closer to the aims.
- Identify and develop the *Leadership and Governance* for a Triple Aim effort
- Develop a brisk and realistic plan for *Execution* on projects and accountabilities for results

Rationale for a Place-Based Strategy

- All the components that are needed to construct a health system are in a region.
- Common values are more likely to emerge.
- Solutions depend on context, and knowledge of context is more accurate locally.
- Platforms for dialogue exist or can be created.
- Other health determinants are attributes of a region.
Guiding Principles for Working in Communities

1. **Boundaries are more permeable.** What takes place in the community occurs in between organizations, either in loosely knit citizen groups, inter-organizational groups, or simply among unorganized citizenry within the community.

2. **It can be more difficult to ensure participation.** Inside organizations, authority can mandate participation. In most social systems there is little basis for requiring people to actually engage and participate in coalition-focused work.

3. **Decision makers are in fact accountable.** At the community level, there remains a genuinely felt belief by citizens that government officials and community leaders are supposed to be accountable to the communities they serve.

4. **The process is inherently political.** There is a far greater political dimension to the larger public and civic social system than found in most organizational systems. Although those in power within organizations often retain substantial control over many of the outlets of communication, decision makers in broader social systems must consider that their activities are communicated through a wide set of media prisms not under their direct control.

4. **The issues are public and communal.** Inside organizations, the range of issues and stakeholders involved are usually much more limited, dictated primarily by the organization’s mission. The issues in the public sphere represent the full range of questions facing our modern communities, for example, health, housing, transportation, and jobs.
Some Lessons

- Rely on existing governance structures within your community, and if not, understand you’ll need time to build infrastructure
- Coalitions take a lot of time to keep together and hence it can be hard to accomplish much with them in the beginning.
- Operate under the assumption that all coalitions are unstable.
- Decisions are made by the those who show up.
- Focus on assessing and building on a community’s assets (e.g., strengths and capacities) rather than needs.

Some Lessons

- It’s in the telling of “war stories” that builds the will and confidence across sectors, not always in “best practice”
- Honor your partners but don’t seek consensus:
  - If a region waits for all stakeholders (esp. health systems) to cooperate they will never start. “Leave the door open.”
- What can you do to make them robust and sustainable?
  - Policy change: Oregon CCO, Vermont Blueprint, NC Medicaid
  - Connection with ongoing structure in the community: local government, business community
- Get to know your population. Intimately.
  - Define your scale from the outset (“we’re going to go to 20,000”) and all the stakeholders and assets within the community that can reach that population.
- Assume that you will need to lose a bit of control for much, much more power.
THE SCOTLAND EARLY YEARS COLLABORATIVE

SCOTLAND EARLY YEARS COLLABORATIVE

with Ros Gray
Our context

Community Planning Partnerships
- Partners work together to achieve positive outcomes for citizens

Births = circa 58,000 pa
Premature mortality
Health inequalities
Social inequality
170,000 children live in poverty
Early Years experience has a substantial impact on outcomes

More of our context...

90-100% chance of developmental delays when children experience 6-7 risk factors

The Scottish Government
Early Years Collaborative

-9 months to 1 year
1 year to 30 months
30 months to Primary school
Leadership
5 – 8 years
Scotland – the best place in the world to grow up

Ambition

To make Scotland the best place in the world to grow up in by improving outcomes, and reducing inequalities, for all babies, children, mothers, fathers and families across Scotland to ensure that all children have the best start in life and are ready to succeed.
Stretch Aims

1. Positive pregnancies which result in the birth of more healthy babies by end 2015
   • 15% in the rates of stillbirths and infant mortality
2. 85% of all children reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review, by end-2016
3. 90% of all children reached all of the expected developmental milestones at the time the child starts primary school, by end-2017
Findings - Reach
Glasgow NE & NW Pilot: Percentage of Assessments completed per month (improper median)

<table>
<thead>
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<th>% Completed</th>
<th>0.0%</th>
<th>20.0%</th>
<th>40.0%</th>
<th>60.0%</th>
<th>80.0%</th>
<th>100.0%</th>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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Findings - Communication

<table>
<thead>
<tr>
<th>Communication category by SSLMR</th>
<th>Percentage of completed checks</th>
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</thead>
<tbody>
<tr>
<td>50 words</td>
<td>28%</td>
</tr>
<tr>
<td>21-49 words</td>
<td>62%</td>
</tr>
<tr>
<td>20 words or less</td>
<td>10%</td>
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### Findings - Behaviour

<table>
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<tr>
<th>Behaviour</th>
<th>Percentage of completed checks</th>
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<tr>
<td>No needs (normal range)</td>
<td>73.4%</td>
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<tr>
<td>Possible needs (Borderline range)</td>
<td>12.7%</td>
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<tr>
<td>Probable needs (Abnormal range)</td>
<td>13.9%</td>
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### Findings - Behaviour and Communication

<table>
<thead>
<tr>
<th>SSLMR 50</th>
<th>SDQ No needs</th>
<th>SDQ Poss needs</th>
<th>SDQ Prob needs</th>
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<tr>
<td></td>
<td>23%</td>
<td>2.7%</td>
<td>2%</td>
<td>28%</td>
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<tr>
<td>SSLMR 21-49</td>
<td>43.4%</td>
<td>8.2%</td>
<td>10.4%</td>
<td>62%</td>
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<tr>
<td>SSLMR ≤ 20</td>
<td>6.7%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>73.4%</td>
<td>12.7%</td>
<td>13.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>

…of the 75%
Final Words From Scotland

- Think about your population
- Consider your coalition
- Create the conditions for collaborative working
- Discover the true power of data
- Unite with a common method
- Just start
References

National Performance Framework:
http://www.scotland.gov.uk/About/Performance/scotPerforms

Early Years Framework:
http://www.scotland.gov.uk/Publications/2009/01/13095148/0

Early Years Collaborative: http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/early-years-collaborative

Curriculum for Excellence:
http://www.educationscotland.gov.uk/thecurriculum/index.asp


A guide to Getting It Right For Every Child:
http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-guide

The Scottish Public Health Observatory: http://www.scotpho.org.uk/

Achieving Our Potential:
http://www.scotland.gov.uk/Publications/2008/11/20103815/2

Questions?
THE PUEBLO TRIPLE AIM COUNCIL

Triple Aim Coalition Building: The Pueblo Triple Aim Experience

Pueblo Triple Aim Coalition
Pueblo, Colorado, USA
Hungry for a Change

- $1 Billion spent on healthcare in Pueblo County annually
- 54th out of 59 ranked Colorado counties in Health Behaviors
- Higher rate of obesity than peer counties and state average
- Nearly 30% of all local hospital patients have a diabetes diagnosis
- Higher smoking rate than the state average

Catalysts for Movement

- Mandates
  - State requires local public health improvement plans.
  - Non-profit hospitals required to perform community health needs assessments.

- Cost of Business
  - Employers
  - Healthcare Industry

- New Payer Enters The Market
We’ve Done This Before

- History of Community Success
  - Toughest tobacco ordinance in Colorado

- “Survival of the Community”
  - Geographic and political separation
  - Ability to work together for the benefit of the community with limited resources from outside of the community

Wide Ranging Support

- Key Partners
  - Pueblo Hospitals: St. Mary-Corwin and Parkview
  - Pueblo Community Health Center
  - Pueblo City-County Health Department (staff and Board of Health)
  - Kaiser Permanente
  - Spanish Peaks Behavioral Health
  - Pueblo City Schools
  - Latino Chamber of Commerce
  - Center for Improving Value in Health Care (CIVHC)
Do We Really Want to Do This?

- Community Meetings
  - Triple Aim in Pueblo Workshop: Broad agreement was reached by an initial group of 20 community organizations on the utility of the Triple Aim model and a steering committee was formed to continue the work.
  - Community Leadership Meeting: Over 50 key healthcare and community leaders met for an update on activities Pueblo Triple Aim Steering Committee and tasked the Steering Committee to create a strategic plan for Pueblo's Triple Aim efforts.

New Kid on the Block

- Strategic Plan Action: Create a New Non-Profit
  - Pueblo Triple Aim Corporation
  - Neutral Convener
  - Mix of Health and Non-Health Members
  - All “C” Suite Level Representation
  - Steering Committee Remains “Boots on the Ground”
Pueblo Triple Aim Coalition

- High Level Policy and Governing Board: Pueblo Triple Aim Corporation
  - High Level Community Support

- Advisory Council: Pueblo Triple Aim Steering Committee
  - “Boots on the Ground”

- Ad-Hoc Committees: Portfolio Specific
  - Deal with shorter-term, single issue needs

The Successes

- Engaged Leaders-Health is a Priority
  - Steering Committee
  - Board of Directors
  - Health is a community issue

- They’re Calling Us!
  - Data capture and collection
  - Funders looking at new models
  - State groups
The Challenges

- Others to Engage
  - Business Community
  - Insurance Community—Public And Private
  - Faith Community

- Short Term Mentality

- We Don’t Know What We Don’t Know

- Finding the Right Place to “Plug In”

Who To Call If You Want
Pueblo Chiles

Matt Guy
Pueblo Triple Aim Corporation
Managing Director
Southeastern Colorado Area Health Education Center
Executive Director
matt.guy@secahec.org
719.544.7833
Questions?

THE FAMILY VAN
Mobile clinics are improving health equity across the country!

- Improve access
- Reduce disparities
- Save costs

Mobile Health Clinics
Improving Access to Healthcare

Minorities
Race: 41% of clients identify as non-White
Ethnicity: 34% of clients identify as Latino

Men and Women

Uninsured and low income
1/3 have undiagnosed chronic diseases

- Community Health Workers
- Researchers
- Partner Agencies
- Registered Dieticians
- Volunteers
Addressing Social Determinants of Health

- Community linkages: 70 community partners!
- Local Gyms
- Health insurance
- Neighborhood health centers
- Legal aid
- WIC, SNAP, Farmers Markets
- Housing, employment
- Health isn’t just healthcare!
- Improved Health
- Improved Experience of Care
- Reduced Cost

Outcomes
- Best Practice for Clinical to Community Linkages
- 45% reduction in risk of stroke
- 32% reduction in risk of heart attack
- Early detection of previously undiagnosed chronic disease
- Five Year Average ROI 27:1
THE FAMILY VAN
Collaborative Design for increased Engagement

- 2 design partners
- 4 youth organizations
- 12 Outreach workers
- 2 Academic Institutions
- 1 Community Health Center

Redesign Results

- Over 100% increase in # of youth using the service in the first 6 months
Challenges of Collaborating

**Goal:** All people in Roxbury are healthier and receiving the right care, at the right time, and in the right place

**Who Is Involved**
Hospitals, CHCs, employers, researchers,

**What's Working**
- Quality dashboard
- Increased patient engagement via portals

**What's Needed**
- Strengthen clinical to community linkages
- Community Engagement
- Take Action

Lessons on Collective Impact

- Community Centered Quality Improvement Works!
- Adapt a governance structure that suits the goals
- Engage the target population in the design phase not just implementation
Questions?

CINCINNATI CHILDREN’S HOSPITAL MEDICAL CENTER
2015 Strategic Goals
Hamilton County: 190,000 children age birth - 17 years

Goal and Initiatives

Lead, advocate and collaborate to measurably improve the health of local children and reduce disparities in targeted populations

- Reduce the occurrence of unintentional pediatric injuries among children less than 5 by 30% in 5 communities by June 30, 2015.
- Reduce infant mortality by 15%, (3 infant deaths per year), in the neighborhoods of Avondale and Price Hill by June 30, 2015.
- Spread Frederick Douglass Prototype to at least 2 other CPS/Norwood Elementary Schools by June 30, 2015.
- Reduce the use of the ED and inpatient services by 20% in asthmatic children in Hamilton County covered by Medicaid by June 30, 2015.

Key Driver Diagram

GLOBAL AIM

Lead, advocate & collaborate to measurably improve the health of local children and reduce disparities in targeted populations.

By 2015:
- Reduce occurrence of unintentional pediatric injuries among children <5 by 30% in 5 communities
- Reduce infant mortality 15%, (3 infant deaths per year), in Avondale and Price Hill
- Reduce the use of the ED and inpatient services by asthmatic children 20%
- Spread Frederick Douglass Prototype to at least 2 other CPS/Norwood Elementary Schools

KEY DRIVERS

- Shared vision, leadership, and accountability to improve outcomes, experience, and cost
- Transparent measurement and results sharing that drives continuous learning
- Parents and communities empowered to meet families’ health needs
- Effective, efficient and reliably linked services and supports for families to ensure EVERY child’s needs are met
- Highly effective organizational capacity aligned with existing hospital, community assets
Community Collaboration to Reduce Unintentional Injuries

The Initial Target – Norwood, Ohio

- Population
  - Children ages 1-4 years old
    - Account for 24% of the population 0-16 (@ 43,000/178,000)
    - Over 5,500 injury related ED visits a year in HC
  - Injuries occurring in the home

- Why Norwood
Building Collaboration

• Creating awareness & momentum, build up to 1st Safety Day
  – Sharing injury data, convene Preventing Injuries in Norwood (PIN) steering committee
    • Health, fire, city council, schools, Norwood Service League, ECS, HIPPY, YMCA, Family & Children First, religious council
  – Cooperation & shared priorities
  – Develop shared vision & community buy-in
  – Billboards

• 1st Safety Day: 72 homes

Norwood Safety Days

• 2 volunteers/home – educator & installer
  – Install up to $90 in equipment (smoke/CO detector, stair gate, window guards, cabinet locks, outlet covers)

• PDSAs
  – Recruiting families/homes, volunteer recruitment and training, leadership, referral programs (incentives), education during home visits, engagement tools
### Spread Timeline

- **May 2012** Safety Day #1 (Norwood)
- **Dec 2012** Injury Summit
- **Aug 2013** Safety Day #4 (N, LH, OTR, A, PH)
- **Sept 2012** Safety Day #2 (Norwood)
- **April 2013** Safety Day #3 (N, LH)
- **Oct 2013** Safety Day #5 (LH, OTR, A, PH)

### Community Ownership

N (Norwood), LH (Lincoln Heights), OTR (Over the Rhine), A (Avondale), PH (Price Hill)

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### 12 Month Moving Average of Monthly Rate—All Mechanisms, Ages 1-4yrs (Norwood Zip Code, 45212)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Community</th>
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</thead>
<tbody>
<tr>
<td>6/2012</td>
<td>Safe Talk (pedestrian safety event)</td>
<td>LH, N, LH, OTR</td>
</tr>
<tr>
<td>6/2012</td>
<td>Community meeting</td>
<td>Norwood, Avondale, LH</td>
</tr>
<tr>
<td>2/2013</td>
<td>Community session follow-up</td>
<td>Norwood, Avondale, LH</td>
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<tr>
<td>3/17/13</td>
<td>APF / PTA, Safe Walks</td>
<td>Norwood, Avondale, LH</td>
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<tr>
<td>4/2013</td>
<td>Advocacy Program</td>
<td>Norwood, Avondale, LH</td>
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<tr>
<td>6/2013</td>
<td>Advocacy Program</td>
<td>Norwood, Avondale, LH</td>
</tr>
</tbody>
</table>

Source: CCHMC Trauma Registry and 2010 Census
Injury Rate (Home and Out-of-Home) for Norwood Comparison Homes and Safety Day Homes (Intervention Homes), by Month

Injury Rate (Comparison Grp)
Mean (Comparison Grp) – Baseline Jan2011‐May2012
UCL (Comparison Grp)
LCL (Comparison Grp)

Injury Rate (SD Homes)
Mean (SD Homes) – Baseline Jan2011‐May2012
UCL (SD Homes)
LCL (SD Homes)

Key Learnings

- Engage leadership at each level, develop shared purpose
- On-the-ground prework critical
- Leaders need to engage constituents
- Share and celebrate every success
- Develop “tool kit” to spread, flexibility for community needs
- Understand resources, assets, needs within each community
- Connect community leaders with success stories
- Transparency and rigor – shared data, strong methods, rapid learning
Questions?

Thank You for Joining Us!

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  - nlewis@ihi.org