

PROSPECTUS



Better Health and Lower Costs for Patients with Complex Needs

An IHI Triple Aim Collaborative

July 2014 - June 2015

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Executive Summary

Overview

To accelerate the improvement of care for complex and high-cost patients, IHI invites you to join *Better Health and Lower Costs for Patients with Complex Needs*, an IHI Collaborative beginning July 2014. This initiative will help you plan and implement comprehensive care designs that serve the needs of your most complex, high-risk, and costly patients, resulting in better health outcomes, a better care experience, and lower total cost. Whether your organization has already established a program or is just starting this work, our goal is to help you make a positive and sustainable difference for this population. Within 12 months, participants will be able to do the following:

- Identify a particular high-risk population that will be the focus of your work
- Assess the assets and needs of this population by learning from patients' experiences
- Co-create and execute new care designs to test for impact and cost savings
- Increase the scale and reach of successful care designs in fivefold to tenfold jumps

Timeline

Better Health and Lower Costs for Patients with Complex Needs will begin in July 2014 and will last 12 months. However, because sustained effort is needed to improve population care and results, we anticipate the community will continue for more than one annual cycle, depending on the pace of improvement and the interest of the participants. Over the first 12 months, participants will build and use a robust infrastructure for measurement and improvement. They will also develop, test, and implement better care designs for (and with) their patients with complex needs. Teams who are new to this work will focus on redesigning care for at least 25 patients. Teams further along in the work will continue to improve their care design and scale up the delivery of new models of care in fivefold or tenfold jumps, aiming to serve their entire population of patients with complex needs effectively.

Participation Criteria

This Collaborative is appropriate for organizations committed to better and more cost-effective care of their most complex and costly populations. Typically these organizations are physician groups managing risk, integrated health systems, or health plans but they may also be coalitions of health care providers, health plans, and community partners.

Program Fee

The cost for one year of participation is \$20,000. Interested organizations are encouraged to partner with health care, health plan, and community participants. A limited number of partial scholarships are available for safety-net organizations.

Contact

For further information, please e-mail BetterHealthLowerCosts@ihi.org.

Why Participate?

Healthcare organizations across the United States and the world recognize that a small percentage of the population generates a disproportionately large portion of healthcare costs. In the United States, 5 percent of the patient population generally represents 50 percent of total cost across all payers. This portion of the population is complex and dynamic. These patients may struggle with factors such as chronic physical and mental illness, poverty, and social isolation, and they may move in and out of the high-need category as their circumstances change. High utilization rates coupled with poor outcomes tells us that the standard care system is not working for these individuals. As a result, care of this population is often chaotic, wasting resources and placing significant burdens on patients and staff. The urgency to improve care for these patients is growing as systems in the United States and other countries place more emphasis on care continuity, patient-centeredness, and reducing overall cost.

IHI has been working with over 140 organizations around the world for a number of years on population management with a focus on improving care, cost, and health for the population of patients with complex needs. Organizations who deeply listen to patient's stories are able to co-design care approaches with patients to boost health and experience while driving down total cost. This work shows that in many cases, better care designs and greater patient and community engagement can result in financially sustainable programs that improve health outcomes at lower cost.

Who Should Participate?

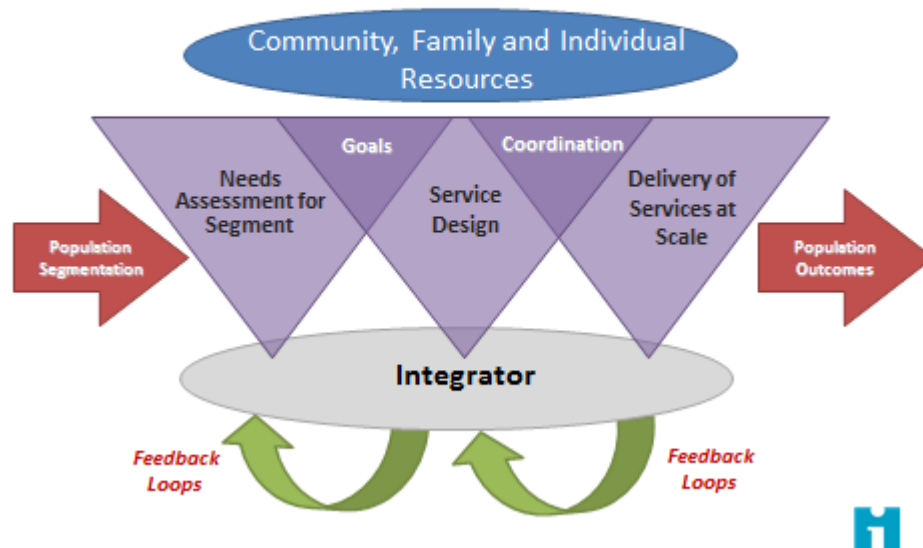
Organizations that provide (or plan to provide) care for defined population groups while bearing the financial risk of caring for those groups will benefit from participation in this learning community. Typically participants are health systems, but community organizations working to improve the welfare of a geographically defined population will also benefit. Participants may include:

- Integrated systems of health delivery and financing operating anywhere in the world.
- Accountable Care Organizations (ACOs) or integrated delivery systems that are pursuing other new payment models.
- Physician group ACOs.
- Private or public employers seeking better health and value for employees.
- Private or publicly funded health plans committed to improving value.
- Organizations embarking on innovative, population-focused designs.
- Safety-net health care systems facing rising demands and flat budgets.
- Regional coalitions collaborating on a community-wide health issue or working to ensure access for all while controlling costs.
- Public health departments or social agencies focused on populations with complex health issues.
- Primary care or multi-specialty physician groups interested in risk sharing and cost savings arrangements.

Approach

Better Health and Lower Costs for Patients with Complex Needs is based upon the framework of the IHI Triple Aim and incorporates key lessons from over six years of intensive work in this area (<http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.asp>). The diagram below depicts the framework that participants will use to develop new models of care for their complex populations. Organizations participating in the Collaborative will ideally seek to manage this sequence of steps—needs assessment, service design, and delivery of services at scale—in coordination with a broad set of stakeholders and community resources to produce outcomes at a population level. IHI calls these coordinating organizations “integrators.”

Managing Services for a Population



Population Identification and Segmentation

Many patients who generate very high costs in a given year are experiencing temporary crises that will be resolved in a short period of time. Others, however, may have complex needs over an extended time. This learning community will focus on the latter group. IHI recommends using a blend of methods to identify the persistently high-risk segment of the population, including reviewing past utilization and cost data, engaging with front-line providers to gather qualitative information about high-risk patients, and engaging in direct dialogue with individual patients with complex ongoing needs.

Strengths and Needs Assessment

After teams select a segment of their population with complex and costly needs, to focus on, they will assess the specific strengths and needs of this segment. For example, a team focusing on a “tri-morbid” population — that is, a population coping with mental health issues, chronic physical

illness, and substance abuse—would account for all three areas of need, coping strategies and existing supports in their assessment. The function of the assessment is to clearly articulate the goals in caring for this population and to begin to outline key community partners who will be integral to fostering better health and cost outcomes.

Service Design

This phase focuses on the actual design of care for the population of focus. It includes all relevant stakeholders and addresses the needs and goals articulated in the previous phase. In some cases, teams will discover that new services need to be created. However, teams often find that many or most of the right services already exist in some form in their community but that these services are not well integrated or available at the necessary scale. Similarly, teams learn from patients why certain interventions are not impactful, and are able to co-design new approaches that are more likely to succeed. At a high level, this phase will help teams address system-level challenges related to mobilizing the support of leadership, using reliability science, promoting effective teamwork across care settings, employing patient-centered care designs, and developing an understanding of the social determinants of health.

Delivery of New Services at Scale

Once teams understand their population's needs and redesign services, their next challenge is to find a way to deliver these services efficiently to all individuals in the population. Many failures occur when organizations attempt to jump directly from a successful pilot to full-scale implementation. IHI recommends increasing the scale of testing and learning in fivefold (5X) increments. This enables teams to discover and address previously unknown system constraints; it also allows teams to spot opportunities for efficiency. Whether teams are just starting out or are already implementing changes in the way their organizations care for patients with complex needs, IHI will help all participants design, test, and scale up their plans for improvement.

Expanding Capabilities of “Integrator” Organizations

In addition to developing new care designs for the chosen complex population, teams will learn ways to coordinate the efforts of many stakeholders who are working together to improve outcomes their population. For instance, participants will learn to articulate a persuasive strategic rationale and business strategy for redesigning care for a specific population. They will also learn to build effective multi-disciplinary and multi-stakeholder teams.

System of Measurement

Participants in the Collaborative will develop measures of outcomes at the population level related to care, health, and cost. Sample measures are shown below. A more detailed description of measurement strategies for the IHI Triple Aim is available at the IHI website¹.

Component	Measures
Population Health	Self-rated health status
Cost	Total per capita cost; hospital and emergency department utilization rates
Experience of care	Individual perception of experience (survey); control of physiological factors such as blood pressure; readmissions and ambulatory care-sensitive hospitalizations

Participants will begin the process of developing measures by identifying and exploring currently available data from a range of sources. Next, they will identify appropriate project level measures for both outcomes (e.g., percent of the population achieving health goals or placed in permanent housing) and processes likely to lead to those outcomes (e.g., number of patients referred to a community health worker or percent of patients screened for depression). The project level measures will link logically to the care designs being tested and will be used throughout the collaborative to track progress towards intended outcomes.

Participants will gather and display time series data on process and outcome measures and will integrate the data to drive further improvement in care.

Learning Activities

Better Health and Lower Costs for Patients with Complex Needs is patterned on IHI's Breakthrough Series Collaborative Model.² Using an “all teach, all learn” philosophy, collaboratives include pre-work, team coaching, face-to-face meetings, and web-based meetings where teams learn from our expert faculty (see Appendix) and each other. The schedule of activities is below. Some of these activities will focus on topics relevant to all teams and others will focus on special topics.

2014-2015 Schedule of Activities

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Getting Started Pework Calls	●	●										
Community Calls: Building Infrastructure			●	●								
Community Calls					●	●	●		●	●		●
Special Topic Calls					●	●	●		●	●		●
Measurement Calls					●		●		●		●	
Leadership Calls			●				●			●		
Learning Sessions				●				●			●	
Action Periods												
Harvest Meeting												●

- Getting Started:** Participants will organize their improvement teams, gather data on potential focus populations, identify data sources and measures, identify partners and assets within their communities, and assess their team's current level of expertise in using improvement methods. During this period teams will also begin to connect to the learning community and gain access to IHI's Extranet and listserv for participants.
- Building and Enhancing Infrastructure:** Sites will participate in a series of webinars focused on building the infrastructure necessary to pursue population management and achieve better health outcomes and better patient experience of care at lower costs for this population of focus. Using web-based calls, the IHI faculty will introduce principles and coach teams through a sequence of key activities including population selection, development of a

cogent purpose, team formation, development of a measurement system and a portfolio of projects, and approaches to reducing costs. The infrastructure phase will yield a specific plan for each site that will be the focus of their work for the remainder of the Collaborative.

- **Learning Sessions:** Teams will convene for one in-person and two all-day virtual learning sessions. These meetings provide an opportunity for learning, networking, and refinement of action plans. We strongly encourage the participation of two to five members of your team at all three meetings. For those who cannot attend the in-person meeting, there will be an option to participate virtually in selected sessions. Teams will come to learning sessions with a summary of their work to date, usually in the form of a storyboard presentation that will be shared with all of the other participants.
- **Action Periods:** During the action periods between learning sessions, teams will use rapid cycle testing to advance their individual program plans. Action periods are devoted to testing new changes and to spreading those that have shown success. The intent is for participants to scale up from smaller to larger populations as quickly as possible. Teams will report bi-monthly on their activities and measures, and they will participate in the all-team calls described below.
- **Monthly All-Team Calls:** IHI faculty members will lead one-hour, monthly virtual sessions to help all teams explore the steps involved in designing effective and sustainable care delivery models. Calls will address issues relevant to the challenges the teams are facing and will feature the work of teams inside and outside the initiative.
- **Content & Coaching Calls:** Once a month, IHI faculty members will lead one-hour virtual sessions to explore specific content in greater depth. Examples of call topics include: business models relevant to different settings; community activation strategies; predictive modeling; and workforce development. In each session at least one team will have the opportunity to present its work and receive active coaching and recommendations from IHI faculty members and the other teams.
- **Leadership Calls:** Support from senior leaders is crucial to the success of any significant endeavor. To that end, IHI will periodically offer calls for senior leaders of Collaborative teams. Discussions will focus on strategic aspects of the Triple Aim, will-building, and governance issues.
- **Harvesting:** In June 2015, all teams will share their results and learning in a virtual harvesting session.
- **Links to Other IHI Programming:** As needed, IHI faculty members will refer teams to additional IHI improvement training related to their content focus.

Throughout the Collaborative, participants will have access to:

- Guidance from our expert faculty on the key content and methodologies necessary to design care models that deliver cost savings and higher quality care. This guidance will be customized to each organization's unique context and population of focus.
- Guidance on testing, implementing, and scaling up new care models with a focus on achieving financial sustainability.
- Support around measurement strategies and data collection.
- Specific workforce and asset-based strategies for community engagement and activation.

- Coaching to build each team's capability to learn what works in its setting, using the methodologies and knowledge in the Collaborative.
- Opportunities to explore additional onsite and virtual coaching services beyond the activities of the Collaborative.

Expectations of the Participating Sites

To succeed in the *IHI Better Health and Lower Costs for Patients with Complex Needs* Collaborative, participating sites will need to exhibit certain characteristics:

- **Senior Leadership Support:** Because of the strategic and challenging nature of improving care, cost, and health for complex populations, participating teams must have the explicit support of their senior leadership, and these leaders must stay actively connected to the team's work. To maximize results, the Collaborative should be a recognized priority supported by each organization's senior leadership and governing board. The IHI team will convene the senior leaders periodically through a series of calls and will dedicate time during learning sessions to discuss leadership and governance.
- **Dedicated Project Resources:** The organization's identified senior leader for Collaborative should appoint a high-level project leader to head the collaborative team. This project leader will oversee the day-to-day activities of the team and needs the time, resources, and accountability to succeed. Because of the challenges in securing population-level data, we strongly recommend also designating a data and measurement lead. Depending on the scope of the project, we estimate this project leader will need to dedicate 20 to 40% of their time. A multi-disciplinary team, focused on the activities of the Collaborative generally consists of 6-10 members who may represent a wide range of stakeholders, including clinicians, workers providing wrap-around care to patients executive leaders, patients, community partners, and payers.
- **Improvement Skills and a Record of Successful Improvement:** To succeed in this work requires strong improvement capabilities. Successful participants will commit to learning quality improvement methods or already be skilled and agile in using the Model for Improvement or other improvement methods. These include iterative learning through running small tests of change, testing new designs at ever-increasing scale, and implementing change throughout the system or community. IHI has a wide array of programming that can help bolster the improvement skills of team members and community partners.
- **Dedicated Support for Measurement and Data Infrastructure:** Few organizations or coalitions have all the data they need to understand and improve care for their patients with complex needs. In addition to using the data already available, most participants will need to develop new ways to collect and use data, including looking beyond their own data systems to external sources. The IHI team will convene the measurement leads from each team via periodic coaching calls to work through common measurement challenges.
- **Partnering and Inclusion:** Participating organizations will need to reach beyond their usual boundaries to develop multi-stakeholder partnerships. Partnering relationships often include health care organizations and groups such as social service agencies, local governments, public health departments, educational institutions, employers, and other community groups. These partnerships may also include civic, religious, and other non-profit or voluntary organizations focused on improving the health of the community. IHI

encourages participating sites to include patient, family, and community representatives as active team members.

To Enroll

If your system or coalition is interested in enrolling in *the Better Health and Lower Costs for Patients with Complex Needs* Collaborative, please e-mail BetterHealthLowerCosts@ihi.org. Teams are encouraged to enroll at least one month prior to the start date in order to allow time to prepare for the Collaborative work.

To Learn More

Join an upcoming informational call led by Catherine Craig, Cory Sevin, and John Whittington on March 25 at 12:00 pm -1:00 pm EST. E-mail BetterHealthLowerCosts@ihi.org for connection details.

IHI faculty members are also available for individual calls with interested organizations. If you'd like to set up a conversation with a member of our faculty to talk about this opportunity, please e-mail BetterHealthLowerCosts@ihi.org.

Appendix

Core Faculty

Catherine Craig, MPA, MSW, has over 13 years of experience in systems change and bridging research and practice. She has expertise in fostering collaboration and navigating the intersections between policy areas and organizations by identifying and translating common priorities. Ms. Craig is adept at designing and implementing interactive processes with multiple stakeholders to set strategic directions, and she excels in sensitively fostering involvement by disenfranchised groups. She was a founding senior manager of Community Solutions, a national nonprofit where she served as the director of healthy communities. She was also a research scientist at the New York City Department of Health and Mental Hygiene, where she designed and led learning collaboratives to boost mental health outcomes, and a consultant to the Fire Department of New York in its effort to boost minority applicants to the firefighting academy. She has deployed her clinical skills with diverse populations in inpatient and community settings in the United States and Latin America. She is currently an independent consultant based in France.

Dr. Alan Glaseroff is Co-Director of Stanford Coordinated Care, a service for patients with complex chronic illness. Dr. Glaseroff, a member of the Innovation Brain Trust for the UniteHERE Health Trust, is a Clinical Advisor to the PBGH Intensive Outpatient Care Program CMMI Innovation Grant that began in July 2012, served on the NCQA Patient-Centered Medical Home Advisory Committee 2009-2010, the “Let’s Get Healthy California” expert task force in 2012 - present, and the Executive Committee for the CA Advanced Primary Care Institute in 2013. Dr. Glaseroff was named the California Family Physician of the Year for 2009.

Dr. Glaseroff’s interests focus on the intersection of the meaning of patient-centered care, patient activation, and the key role of self-management within the context of chronic conditions.

Ann Lindsay MD is Co-Director of Stanford Coordinated Care (SCC). SCC is capitated for primary care of Stanford employees and adult dependents with complex chronic health conditions. Care is provided through a partnership between patients and families and their multidisciplinary care team including physical therapy, behavioral health, nutrition therapy and clinical pharmacy and primary care. Emphasis is placed on the patient’s own goals, care coordination with specialists, and on helping patients gain the skills to be healthy with whatever conditions they faced with. SCC has developed a dashboard that pulls from EPIC EHR to risk assess patients and identify care gaps and a Team Training Center to share the model of care.

Prior to moving to Stanford in 2011, Dr Lindsay shared a family practice with her husband, Dr Alan Glaseroff, in rural Northern California for 28 years. During this time she served as County Health Officer for 18 years and was active in the leadership of the California Conference of Local Health Officers in Sacramento. In 2006 she received the Plessner Award from the California Medical Association as the physician who best exemplified the practice and ethics of a rural practitioner.

She currently serves on the Clinical Advisory Committee for the Pacific Business Group on Health CMMI supported project, Intensive Outpatient Care Program, which seeks to enroll 27,000 patients in three states by 2015. She is a fellow in the California Health Care Foundation Leadership Program

Kevin Nolan, Mstat, MA, is a statistician and consultant at Associates in Process Improvement and a Senior Fellow at IHI. He has focused on developing methods to help organizations accelerate their rate of improvement, both within and outside of the field of health care. He has served on the faculty of various IHI Breakthrough Series Collaborative Meetings, the Hospital Flow Innovation Community, the Operational and Clinical Improvement in the Emergency Department Community, and large system spread projects. Kevin holds a bachelor's degree in mechanical engineering from The Catholic University of America, a master's degree in measurement from the University of Maryland, and a master's degree in statistics, also from the University of Maryland. He is a co-author of the book *The Improvement Guide: A Practical Approach to Improving Organizational Performance*.

Rebecca Ramsay, BSN, MPH, received her BSN at the University of Madison, WI and her Masters in Public Health at Portland State University in 2005. During her 8 year tenure at CareOregon she has worked to develop and implement an innovative, multi-disciplinary team-based care management program which targets the plan's highest risk members. In addition to developing CareOregon's CareSupport Program, Rebecca has supported CareOregon's Primary Care Renewal program which facilitated the transition of numerous safety-net primary care practices to patient and population-centered primary care homes. Most recently, Rebecca has developed and implemented CareOregon's Health Resilience Program which deploys specially trained non-medical outreach workers, anchored to primary care practices, to partner with high cost patients who suffer from multiple chronic medical conditions overlaid with mental illness, exposure to trauma and/or substance use disorders. Addressing the sociobehavioral risk factors and the social determinants of health for this target population is a focus for this new program.

Cory B. Sevin, RN, MSN, NP, is a director with the Institute for Healthcare Improvement. With IHI, she has led work in spread, redesigning the clinical office practice, improving transitions into home healthcare, improving emergency department flow, and improving transitions in care to reduce readmissions. MS. Sevin is a nurse practitioner with a clinical specialty in adolescent, preventative and community health. Past experience includes 26 years working in a variety of community settings, including public health, schools, and community health centers. Before coming to IHI, she was vice president of operations at Clinica Campesina, a community health center in Lafayette, Colorado. She received her BSN in 1976 from the University of Michigan and her MSN in 1980 from the University of Cincinnati.

John Whittington, MD, is the lead faculty for the IHI Triple Aim. He was formerly medical director of knowledge management/patient safety officer at OSF HealthCare. Before holding that position, he worked for many years as a family physician. He has been involved as a faculty member on numerous IHI projects, including safety, spread, inpatient mortality reduction, the Executive Quality Academy, and Engaging Physicians in a Shared Quality Agenda. He is part of the IHI team that works on research and development. He received his undergraduate degree and medical degree from the University of Illinois. He did his residency in family practice at Saint Francis Medical Center in Peoria, Illinois.

References

¹ Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx>

² *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx>