INSTITUTE FOR HEALTHCARE IMPROVEMENT

INSTITUTE FOR HEALTHCARE IMPROVEMENT
TECHNICAL BRIEF FINAL: 90-DAY PROJECT

Triple Aim Prototyping and Learning

Wave 5: August 1- October 31

I. Intent: Working with the participants in the Triple Aim Collaborative develop a detailed understanding of the structure and processes needed to accomplish the Triple Aim. Also identify common barriers that may need to be addressed at the policy level.

II. Background: Waves 2,3,4 included projects on the Triple Aim. The projects successfully provided a conceptual framework for designing a system capable of accomplishing the Triple Aim. The model was interesting enough to attract at least twelve varied organizations to join a six month collaborative effort to refine the model and to test various components of the model. A terrific core team has been assembled to guide this effort. Due to the short time frame, complex subject matter, and varied organizations, designing a system for optimizing the learning and the experience of the participants is a challenge. Providing a design of this learning system is the aim of this Wave 5 project.

III. Contacts:

The primary contacts were the participants in the Triple Aim Collaborative:
Bellin
CareOregon
CareSouth Carolina
Contra Costa
Genesys
Group Health
HealthPartners
Jonkoping County
Primary Care Coalition – Montgomery County
Northern Colorado Health Alliance
Queens Health Network
Vermont

In addition a contact was made with Patricia Smith, CEO of the Alliance of Community Health Plans www.achp.org. This was very fortunate because these health plans include not for profit health plans operating in a small geographic area. Three of their member organizations are in the collaborative: CareOregon, Group Health, and HealthPartners. Five of the health plan CEOs were also interviewed as part of this work.

IV. Potential Prototype Organizations

Collaborative organizations
Members of the Alliance of Community Health Plans.

V. Key Deliverables:
1. List of issues facing each of the organizations
2. Agenda for the October meeting
3. Approach to testing and learning in the collaborative
4. Agenda and curriculum for the Forum Minicourse on the Triple Aim

Work plan

Element	**Action**	**Time line**
1. *Scan*	1. IHI core team interviews each of the participants by phone or in person 2. Identify issues	August 1- September 30
2. Focus	1. Define agenda for Oct meeting 2. Develop tests with prototype sites 3. Focused visits	September 15- October 31
3. Reporting	1. Summarize the set-up 2. Minicourse agenda 2. Write report relating successes and challenges	October 1- October 31

VII. Literature Search:

Completed during waves 2-4.

VIII. Research and Development Team:
- Leader: Tom Nolan – Contact info: tnolan@ihi.org, 301 589 7981
- Colleague (Helper): Andrea Kabcenell and John Whittington

IX. Results:

Deliverable 1. See the two tables below and section X.
Deliverable 2. Agenda for the October Meeting is in Appendix A.
Deliverable 3. Approach to testing and learning in the collaborative. See section X.
Deliverable 4. Agenda for the Forum Minicourse is in Appendix B.
Deliverable new: A new Triple Aim model was also developed during this wave and is in Appendix C

Organizations and the Populations They are Affecting

Organization	Population 6-12 mos.	Population 1-3 yrs	Population > 3yrs
Bellin	Stratum of Bellin emp. Chronic disease grp Subset of Bellin MG SW high school	All employees Persons in Health Plan All MMG patients All HS students	All Brown county
CareOregon	Complex members 6k PC pilot sites 6k	Members 100,000	Portland metro 1.5m
CareSouth Carolina	2 counties 60,000	4 counties 80,000	Pee Dee region elderly 100k
Contra Costa	Diabetes subgroup		East county 300k
Genesys	Genesys emp 3500 Employer 500	Genesys emp. 4500 Genesys HP 6,000 Medicaid mgd, care 5k GM/UAW 20k	Medicare demo 40k Employers 5k

Group Health	Enrollees in GH clinics – 350k	All GH enrollees – 540k	State of Washington
HealthPartners	HP/HPMG – 320,000 cancer and diabetes	Health plan – 730,000	Metro area 4.5m
Jonkoping County	Age related subset 30k Children<4 BMI 9k		Total county 320k
PCC Mont. County	15k enrolled in Montgomery Cares	Low income uninsured 80,000	Entire county 1m
NCHA	High risk to move to high cost	55,000	176,000
QHN	MetroPlus patients in diabetes registry 2000 MetroPlus Adults assigned to QHN PCPs – 9k	All adult diabetes in risk contract; Apply learnings to other DM groups 9k MetroPlus and HealthFirst adults, add community based PCPs – 9-15k	Multiple Disease management programs: Currently only CHF, Asthma & Depressions All Global Risk adults (MetroPlus and HealthFirst) 32k
Vermont	Two pilots – 80-100k	5 pilots with HSAs 200k	State – 615,000

Focus for the Six Months of the Collaborative

Organization	Population 6-12 mos.	Measures	Design Concepts
Bellin	Stratum of Bellin emp. Chronic disease grp Subset of Bellin MG SW high school		

CareOregon	Complex members 6k PC pilot sites 6k	HUI/HEDIS/Cost pmpm	Care mgr protocol Primary care renewal
CareSouth Carolina	2 counties 60,000	Survey of experience Admission rates CVD	Network development Redesign access Audit of cases for cost
Contra Costa	Diabetes subgroup	Diabetes collaborative measures Per capita cost for subgroup	Diabetes collaborative Engage partners Spectrum of prevention
Genesys	Genesys emp 3500 Employer 500		Finance HC delivery Environment
Group Health	Enrollees in GH clinics – 350k	pmpm Survey questions HEDIS index	Medical home Lean redesign Puget Sound Alliance
HealthPartners	HP/HPMG – 320,000 cancer and diabetes	pmpm/equity race & economic/Experience/disease related health measures	10 case review and follow-up Care model process Diabetes inertia prjt. EMR module for cancer Commty outreach
Jonkoping County	Subsets by age 30k Children<4 BMI 9k	Unhealth index HSMR mortality BMI control <4 yrs	Care plan and follow-up Motivating dialogue
PCC Mont. County	15k enrolled in Montgomery Cares	Cost of PC treatable ED visits	Case find using state database Improve connection with PC and treatment in PC

NCHA	High risk to move to high cost	Per capita costs IP admits and ED visits Pt. Experience	Health care and public health collaboration
QHN	MetroPlus patients in diabetes registry 2000 MetroPlus Adults assigned to QHN PCPs – 9k	Per capita cost Diabetes related measures Utilization, e.g. ED visits Patient experience Patient health assessment	Fine tune diabetes care mgt program Redesign PC team Predictive modeling Refinement of care mgt. initiatives
Vermont	Two pilots – 80-100k	Costs for diabetes patients Provider satisfaction Patient self mgt. goals	Chronic care model Community based coordination

Interviews with CEOs of five community health plans

Two of the health plans were associated with hospital dominated health systems, two were associated with large multi-specialty practices, and one was a health plan with no provider affiliation. Some of the highlights include:

- Membership is in the 250,000 – 400,000 range. This is in the range of useful size and is similar in size to a Primary Care Group in England and to Jonkoping County.
- Yearly cost inflation ranges from 6% to 14%.
- None have a cost reduction strategy based on system thinking and engaging doctors. One has a strong program under way in that direction.
- Some do assist small practices with the basics such as helping train office managers
- Building capability of primary care is a strong focus.
- Each of the CEOs was excited about the Triple Aim work and it fit well with their strategic thinking

X. Conclusions/Changes/Design Concepts:

Observations from the collaborative and the review of reports:

- The reports indicated some good thinking and hard work at the meeting and were universally well done.
- The progression over time of the population to be affected was particularly clear and seemed to help their thinking.
- Measures tended to vague.
- Changes were not particularly innovative and will need to be enhanced as time goes on.
- Most of the changes were health care provider focused. Almost no public health or patient based changes (What would one expect when only providers were invited?)
- None had spread plans articulated but the population progression had some implicit spread thinking in them.

Conclusions about the learning system:

- Keep the individual at the center and learn from case examples. CareSouth Carolina and HealthPartners will test a ten case sample to learn about cost and quality of care.
- The time phased progression of population size is a good one because they can work on a tractable issue but still see the context.
- One page reports are mandatory for learning from each other. The first milestone for the collaborative is when all sites have completed one-page reports with run charts.
- We are starting with a concept design in the form of the Triple Aim Model. The model describes "what" we are attempting to do. The collaborative work will test the "how" and the efficacy of the "what." We will assign someone to efficiently catalogue the learning. This is beyond taking notes. At any of our calls - internal or external - we should end by asking what have we learned.
- We will use a "snowball" approach to this. That is there is nothing special about these organizations. What are special are the design changes they are making. Learning will accelerate proportional to how many organizations we are learning from and how diverse they are. The Alliance of Community Health Plans should be added as a separate but affiliated group as a soon as they are ready.
- We should make the evolving Triple Aim model including "what and how" visible to all on the extranet.
- Site visits to all will also be a component of the learning system. Each site visit will be documented with a one page summary report of highlights.
- Evolve the description of a supportive environment and add it to the model.

Recommendations for IHI team:

- Focus on three goals at first: 1. 100% one-page reports 2. First draft operational definitions 3. Make the bi-weekly calls a great experience for the sites.
- Decide how new groups such as ACHP will be accommodated and how the learning will be integrated.
- Focus on health plan and primary care linkages. Areas of investigation include medical home, an integrator with the form of a community health plan connected to a network of medical homes. There are three cases that come up in some of the collaborative sites and the 5 health plans. These case are *patients in the organization's health plan and seen by the*

organization's doctors e.g. HealthPartners and QHN, *patients are in the organization's health plan and seen by community physicians* e.g. CareOregon, HealthPartners, QHN, CCHMC PHO, *patients are seen by the organization's doctors outside of the organization's health plan* e.g. HealthPartners, QHN, Contra Costa.

- Be looking for good examples of building primary care capability and determine the pros and cons of having the PC teams are in or out of the organization.
- Look into technology enablers such as predictive modeling, decision support tools, on line patient health records owned by the individuals. Marc Pierson is a contact on this.

X11. Open Questions:

- What is needed to support acting *with* the family?
- What are the changes in policy and the environment that matter?
- How should doctors be engaged to energetically participate in cost reduction?
- If costs are taken out who are the winners and losers and how do you deal with them?
- Many more …