Institute *for* Healthcare Improvement

Triple Aim for Population Health

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Overview

- Review common terms related to population health
- Introduce the frameworks
  - Triple Aim
  - Pathway to Population Health
- Case Study: Signature Healthcare
- Bright Spot: Dignity Healthcare

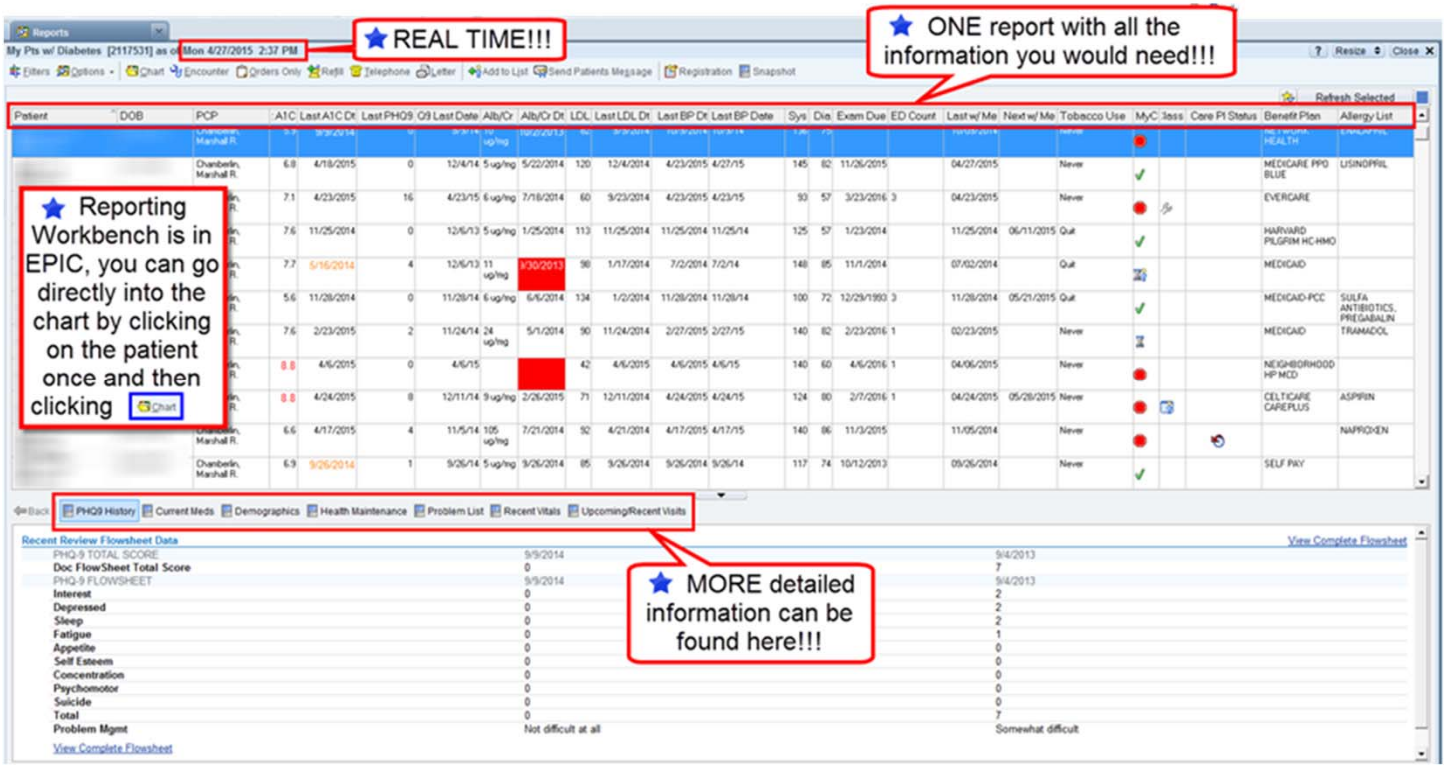
Population Health Management vs. Population Health

Population Health Management

The design, delivery, coordination and payment of services for the defined group of people to achieve specified cost, quality, and health outcomes for that group of people.

Lewis, Ninon. “Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today.” *IHI Leadership Blog.* Institute for Healthcare Improvement, 19 Mar. 2014.

Real World Example



Population Health

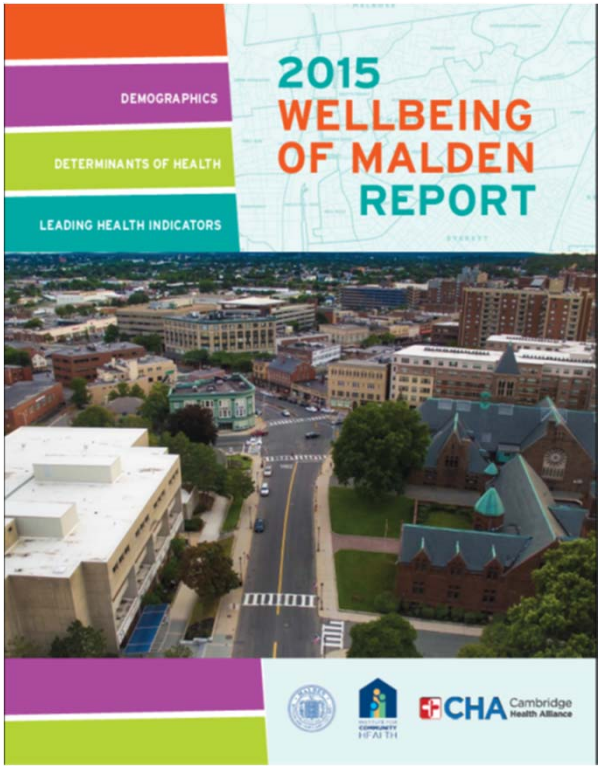
"Population health is defined as the ***health outcomes of a group of individuals, including the distribution of such outcomes within the group***. These groups are often geographic populations, such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group."

-David Kindig, MD, PhD

David Kindig and Greg Stoddart. What is Population Health? American Journal of Public Health 2003: Vol. 93, No. 3, pp. 380-383.

Real World Example

- Summary of indicators related to the overall health and well being of a community
- Dialogue tool for local leaders and community residents to learn about the public health issues affecting their community
- Useful in identifying health-related policy and program needs
- Basis for prioritizing a community's future public health efforts or for evaluating success of past effort
- Leverage funding opportunities



Public Health

Public health promotes and protects the health of people and the communities where they live, learn, work and play.

- American Public Health Association

Oregon Health Authority

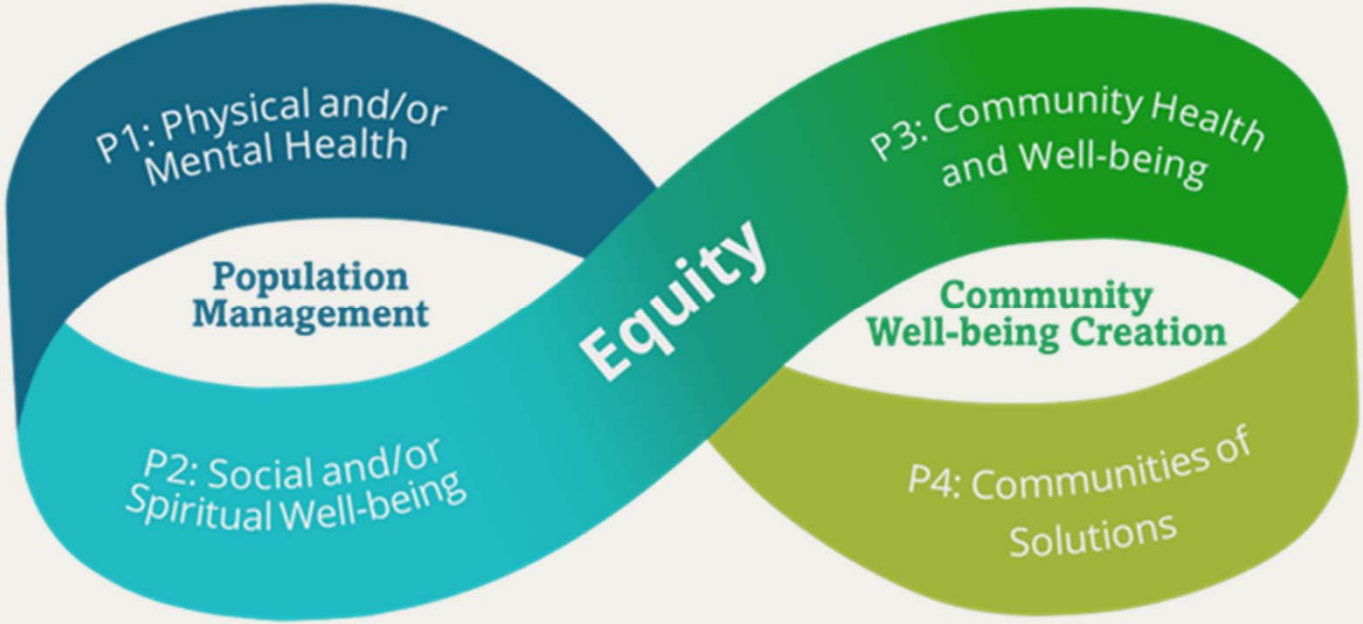
Source: American Public Health Association (https://www.apha.org/what-is-public-health

The Journey to Population Health

Building on the Triple Aim

- Improving the health of the populations
- Improving the patient experience of care
- Reducing the per capita cost of health care

Four Portfolios of Population Health



Source: Pathways to Population Health, 2018

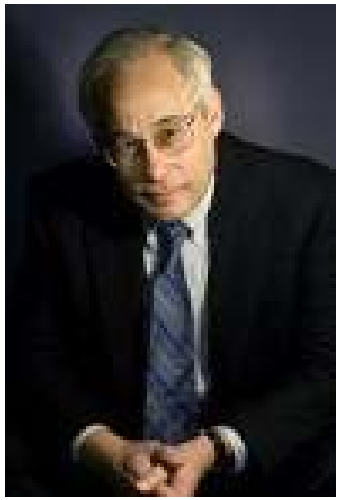
PATHWAYS TO POPULATION HEALTH

Six Foundational Concepts of Population Health

PATHWAYS TO POPULATION HEALTH

What it takes to successfully pursue the Triple Aim?

- Systems thinking
- Recognize the impact of the community on health
- Reducing costs must be cooperative
- Engaged leaders and board



Don Berwick

Source: *The Triple Aim: Why We Still Have a Long Way to Go.* http://www.ihi.org/communities/blogs/the-triple-aim-why-we-still-have-a-long-way-to-go

Case Study:
Signature Healthcare, A Triple Aim Improvement Story

Full story can be access here: http://www.ihi.org/resources/Pages/Publications/SignatureHealthcareTripleAim.aspx

Signature Health Care (Brockton, MA)

- Population:
  - Full Scale – 1450; Segmented - 400 Elders Enrolled in Managed Medicare Product
- The Challenge:
  - To improve screening for fall risk and increase health care proxies for frail elderly population, while increasing patient satisfaction and reducing acute admissions and ER utilization
- Methods Used to Get To Know Their Population:
  - Explored information from its electronic medical record (EMR)
  - Surveys
  - Conversations with patients
  - Discussing patients' needs in care plan meetings and tabulating this information in order to aggregate it

A Portfolio of Projects Stemming From the Needs of Those You Serve

SIGNATURE HEALTHCARE

When they got to know their population, they learned:	***Which led to a portfolio of projects:***

1. Access to care was not an issue (such as time to the next available appointment or % of available appointments the next day or same day).
 	
2. However, these individuals' needs were not met within the typical 15-minute appointment.
 	
3. Care was not standardized in key areas such as: falls, cognition, functional assessments, social needs, depression, and end-of-life planning.
 	
4. Individuals needed social supports like transportation to and from health care appointments; post-discharge Meals on Wheels and medication assistance; as well as end-of-life planning skills and supports.
	• Redesign of complex primary care clinics (including extension of the medical appointment from 15 minutes to 45 minutes)
	• Fall prevention bundle
	• Advanced care planning
	• Care management via reconfigured roles of care team members
	• Weekly care plan meetings with local community organizations to help match the local resources with the needs of particular patients and establish reliable referral processes
	• Partnered with community organizations and agencies on the following projects:
	  • Visiting nurses who conduct home safety evaluations
	  • Chronic disease management classes offered by the local branch of the National Association of Area Agencies on Aging.
	  • Engaged social workers and psychiatric nurses from the community's physical therapy and occupational therapy programs as part of the care team.

A Portfolio Approach Leading to Results

- 50% Decrease in Acute Admissions
- 70% Decrease ER utilization
- Increased referral to Palliative and Hospice Care
- Reduction in Poly-pharmacy
- Improved assessment of fall risk
- Overall improvement in quality of care

Community Health Bright Spot: Dignity Health and Place-based Investing

As of March 31, 2017

22	400+	9,000	62,000	39	993,000
State Network	Affiliated Access Points	Affiliated Physicians	Employees	Acute Care Hospitals	Attributable Members

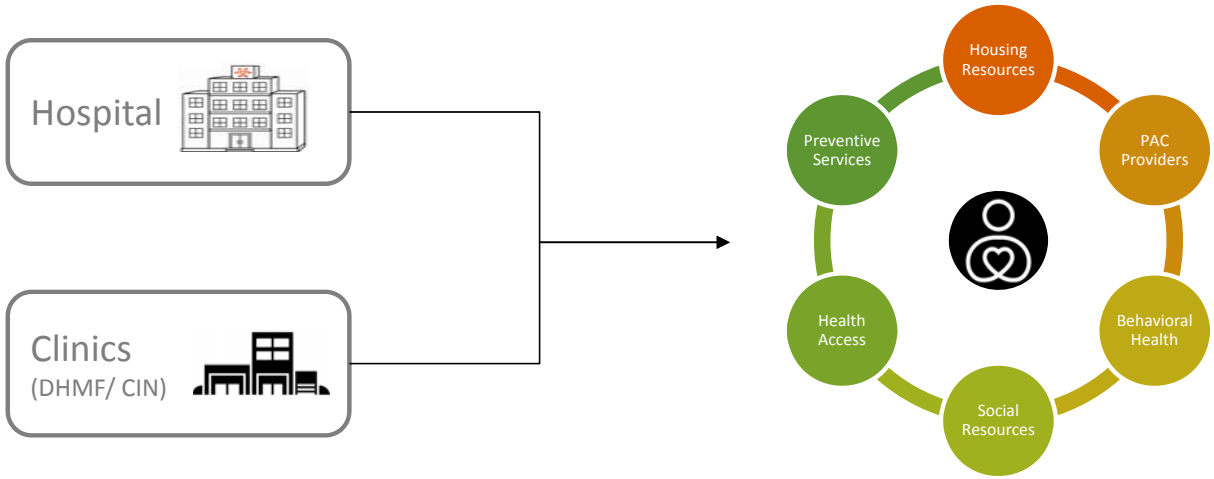
Populations Served & Current Initiatives

Current Portfolio

- Community Health Needs Assessment (CHNA)
- Connected Community Network (CCN)
- Community Investments Program (CIP)
- Social Innovation Partnership Grant (SIPG) Program
- Ecology and Sustainability Program
- Medicaid Transformation Project
- Local Capacity Building
- International Health

Dignity Health.

Coordinated Community Network Initiative



Hospital/Clinics provide care and send electronic referrals to community network based on identified social needs

Community Network receives electronic referral and follows-up with patient to enroll or make additional referrals

Dignity Health.

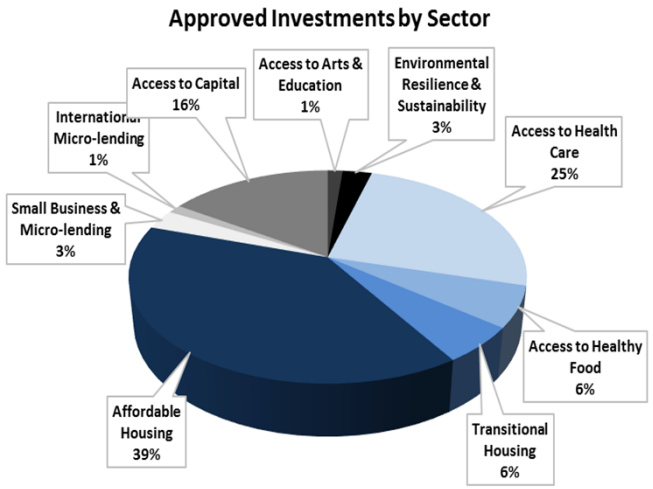
Placed Based Investing

Overview

- Below-market rate loans
- Maximum 7 years
- 80% of loans targeted to Dignity Health service areas
- Maximum loan amount: 10% of CEI allocation

Types

- Direct Loan
- Intermediary Investment
- Line of Credit
- Linked Deposit
- Equity Capital
- Guarantees



Dignity Health.

Expanded Reach and Mission Impact of Community Investments

$140	Total Lending Capital ($ Millions)
74	Total Loan Volume At 3/31/2019
$246	Total Loan Volume Since Inception ($ Millions)

EXAMPLES IN 2018:

- Provided lending capital to a CDFI making loans to industries in the Pacific-Northwest whose renewable energy technology reduces the impact of **climate change**.
- Provided lending capital to a CDE making low-interest rate micro-loans to low-income families in Texas as an alternative to pay-day lenders in an effort to combat **predatory lending**.
- Provided capital to **refurbish housing**.
- Provided loan for the construction of **FQHC**
- Provided predevelopment loan for the construction of **affordable housing**

Community Investments – Funding the Future

Rolland Curtis Apartments

- Innovative Transit Oriented Development in South Los Angeles, next to the Metro Light Rail
- Services-enriched housing model, where coordinators connect residents to services in the community
- Provides housing to low-income families, seniors, and people with special needs

- Located in a federally designated Medically Underserved Area
- 140 units of affordable housing
- Federally Qualified Health Clinic in South Los Angeles
- 8,000 square feet of community-serving commercial space

Thank You!

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