Triple Aim for Population Health

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April 18, 2019
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.

Real World Example

Registries for Chronic Diseases such as Diabetes
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
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

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

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health and Well-being
P4: Communities of Solutions

Source: Pathways to Population Health, 2018
Six Foundational Concepts of Population Health

1. Health and well-being develop over a lifetime.
2. Social determinants drive health and well-being outcomes throughout the life course.
3. Place is a determinant of health, well-being, and equity.
4. The health system needs to address the key demographic shifts of our time.
5. The health system can embrace innovative financial models and deploy existing assets for greater value.
6. Health creation requires partnership because health care only holds a part of the puzzle.

What creates health?
How can health care engage?
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

Case Study: Signature Healthcare, A Triple Aim Improvement Story

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

<table>
<thead>
<tr>
<th>When they got to know their population, they learned:</th>
<th>Which led to a portfolio of projects:</th>
</tr>
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<tbody>
<tr>
<td>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).</td>
<td>• Redesign of complex primary care clinics (including extension of the medical appointment from 15 minutes to 45 minutes)</td>
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<tr>
<td>2. However, these individuals’ needs were not met within the typical 15-minute appointment.</td>
<td>• Fall prevention bundle</td>
</tr>
<tr>
<td>3. Care was not standardized in key areas such as: falls, cognition, functional assessments, social needs, depression, and end-of-life planning.</td>
<td>• Advanced care planning</td>
</tr>
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<td>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.</td>
<td>• Care management via reconfigured roles of care team members</td>
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<td>• 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</td>
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<td>• Partnered with community organizations and agencies on the following projects:</td>
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<td>• Visiting nurses who conduct home safety evaluations</td>
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<td>• Chronic disease management classes offered by the local branch of the National Association of Area Agencies on Aging.</td>
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<tr>
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<td>• Engaged social workers and psychiatric nurses from the community’s physical therapy and occupational therapy programs as part of the care team.</td>
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</table>
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
Humankindness helps heal the whole person—body, mind, and spirit.

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<tr>
<td><strong>22</strong> State Network</td>
<td><strong>400+</strong> Affiliated Access Points</td>
<td><strong>9,000</strong> Affiliated Physicians</td>
<td><strong>62,000</strong> Employees</td>
<td><strong>39</strong> Acute Care Hospitals</td>
</tr>
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As of March 31, 2017

Hello humankindness

Dignity Health
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
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
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
### Expanded Reach and Mission Impact of Community Investments

<table>
<thead>
<tr>
<th>Total Lending Capital ($ Millions)</th>
<th>$140</th>
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<tbody>
<tr>
<td>Total Loan Volume At 3/31/2019</td>
<td>74</td>
</tr>
<tr>
<td>Total Loan Volume Since Inception ($ Millions)</td>
<td>$246</td>
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**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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