Putting it Together: Projects that Require Collective Action

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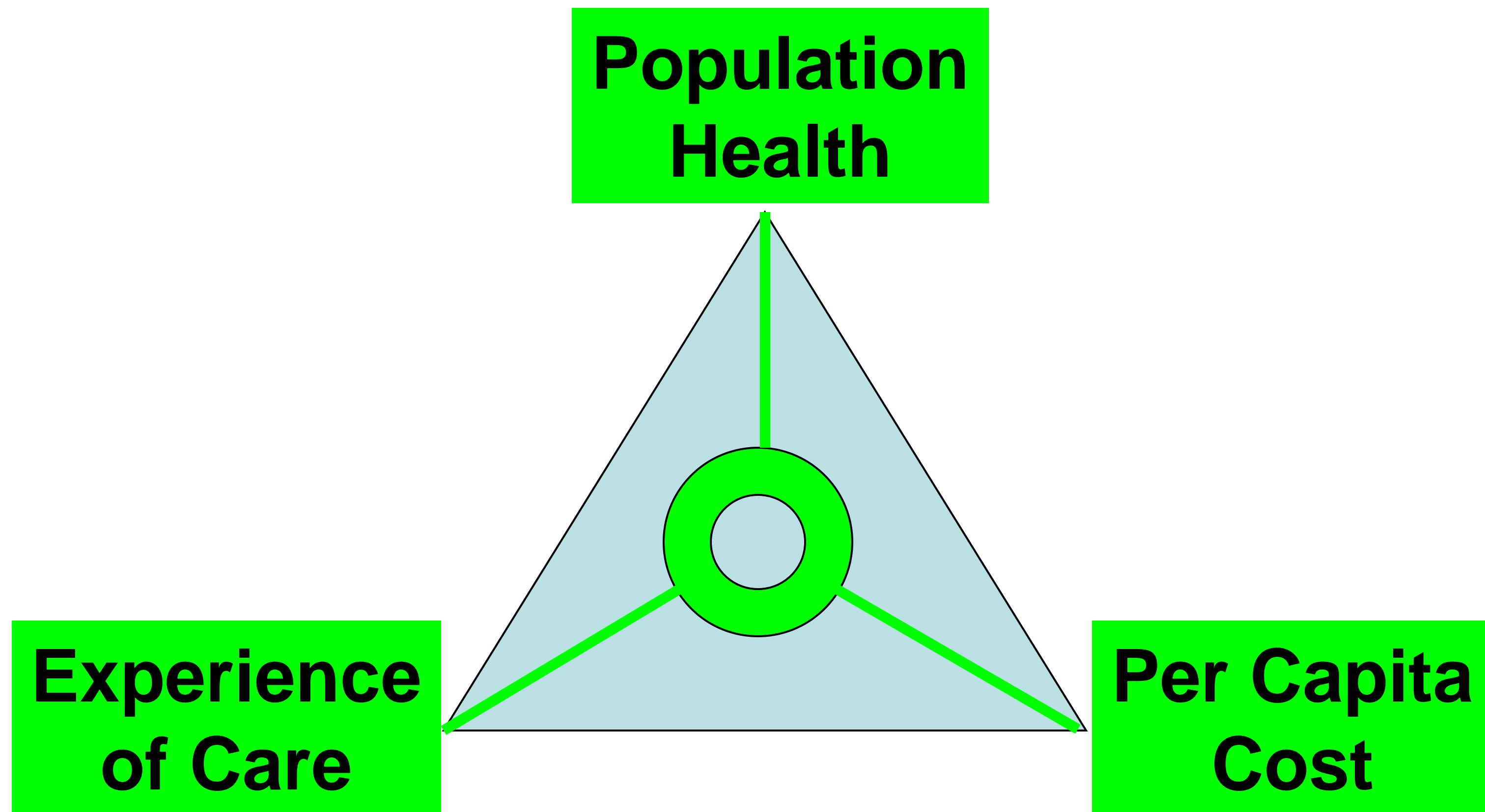
Three Dimensions of Value



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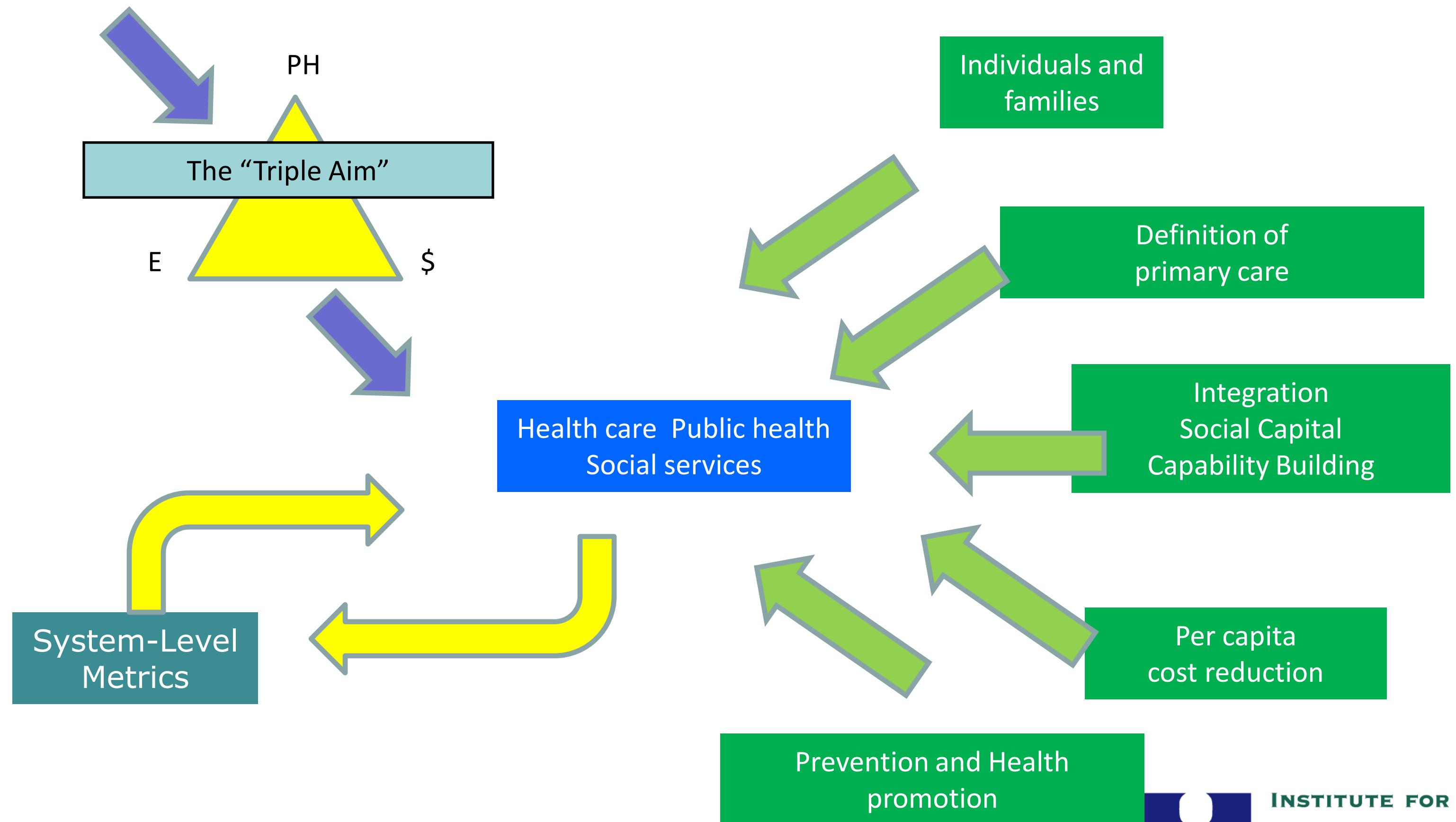
Design of a Triple Aim Enterprise



Potential Triple Aim Population Outcome Measures

Dimension	Measure
Population Health	1. Health Outcomes: ▪ Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates ▪ Health/Functional Status: single question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12) ▪ Healthy Life Expectancy (HLE): combines life expectancy and health status into a single measure, reflecting remaining years of life in good health
	2. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions
	3. Risk Status: Behavioral risk factors include smoking, alcohol, physical activity, and diet. Physiological risk factors include blood pressure, BMI, cholesterol, and blood glucose. (possible measure: a composite Health Risk Appraisal (HRA) score)
Experience of Care	1. Standard questions from patient surveys, for example: ▪ Global questions from US CAHPS or How's Your Health surveys ▪ Experience questions from NHS World Class Commissioning or CareQuality Commission ▪ Likelihood to recommend
	2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)
Per Capita Cost	1. Total cost per member of the population per month
	2. Hospital and ED utilization rate and/or cost

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Global Triple Aim Participants

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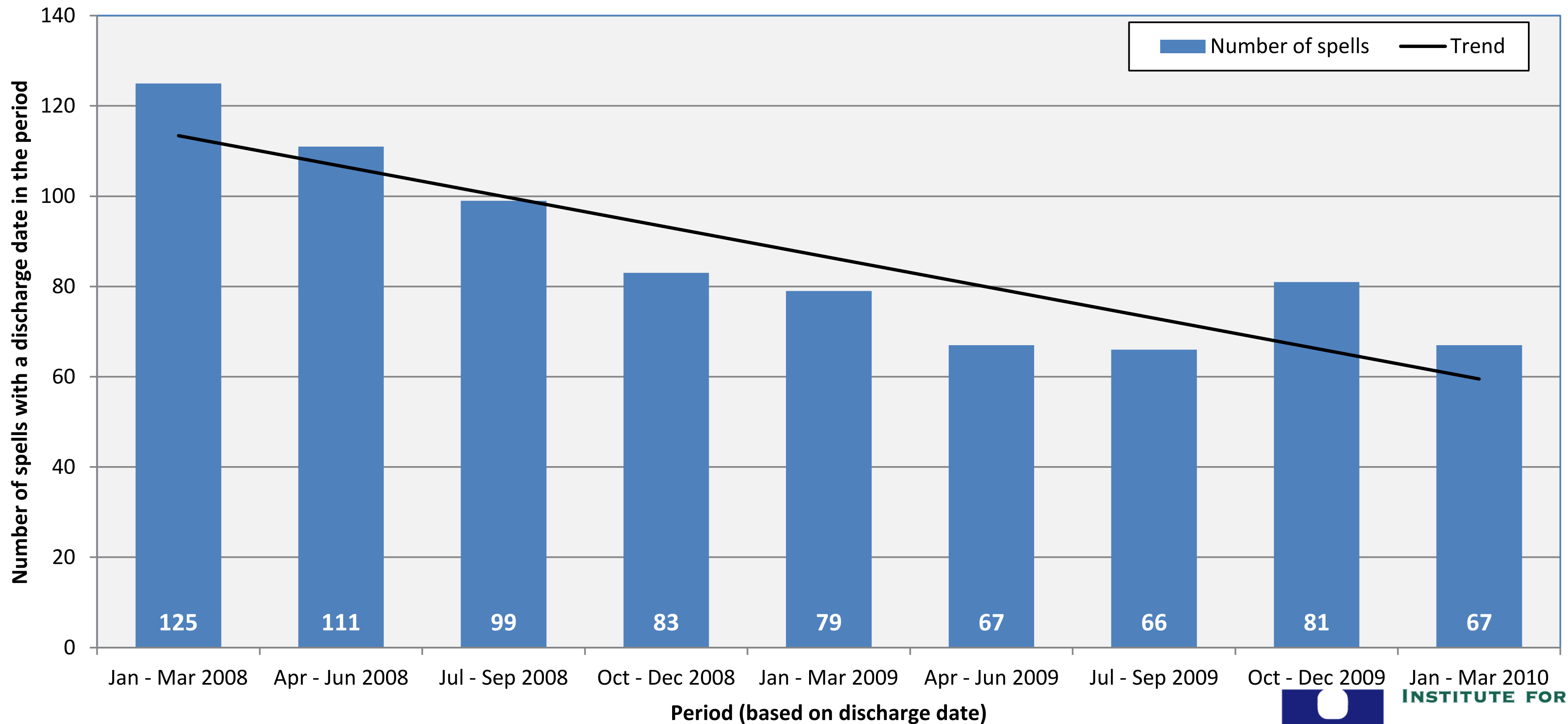
MI Admissions



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Achieving Triple Aim Regional Results

- Purpose
- Integration and governance
- Measurement/intelligence
- Portfolio of projects and investments
- Execution of you projects

Portfolio of Projects and Investments

Initiative	Typical projects	Typical investments	Capability building
Regional intelligence	Data from ambulances, data from EDs	Fund a few positions to receive, maintain, and analyze the data for the community	Timely knowledge of community health status
Primary care	Redefinition of primary care	Connections with community resources	
Longitudinal experience of care	Care for the socially complex	Community based health promotion and care mgt.	Development of new skills in the workforce
Payment and cost control	Improving health and lowering cost for employees	Health risk appraisals, and health coaching	Driving cost savings through population health
Community health	Falls with harm in the community	Integration of existing efforts, ACO savings	Cooperation, improvement skills, joint investing

A Community Approach for a Population Health Project

- Adaptive Leadership- “honest broker”
- Community Assessment of ongoing work and resource
- Infrastructure to support the project work: project management, quality improvement, data analytics and logistical support
- Common Working Knowledge- QI Training

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A Community Approach for a Population Health Project

- High Level Measures- with multiple agencies it is important to be focused on the big outcome
- Funders -Get funders involved in a unified way that will support the overall aims
- Communication- across agencies and within the community

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A Community Approach for a Population Health Project

- Design issues -high risk population segment, self management issues, care coordination issues , economic or social factors and patient and family involvement including self management issues
- *Helpful Reference: Collective Impact By John Kania & Mark Kramer Stanford Social Innovation Review Winter 2011*

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Questions?