The Triple Aim: Linking Populations and Quality

Leslie Porth, Senior Vice President of Strategic Quality Initiatives
August 7, 2015
Health Care Policy and the Affordable Care Act
## Historical Shift in United States Causes of Death

<table>
<thead>
<tr>
<th>Ranked in Order</th>
<th>1900 (rate per 100,000)</th>
<th>2010 (rate per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pneumonia and influenza (202)</td>
<td>Diseases of the heart (194)</td>
</tr>
<tr>
<td>2</td>
<td>Tuberculosis (194)</td>
<td>Malignant neoplasms (186)</td>
</tr>
<tr>
<td>3</td>
<td>Diarrhea (142)</td>
<td>Chronic lower respiratory diseases (45)</td>
</tr>
<tr>
<td>4</td>
<td>Diseases of the heart (137)</td>
<td>Cerebrovascular diseases (42)</td>
</tr>
<tr>
<td>5</td>
<td>Intracranial lesions of vascular origin (107)</td>
<td>Unintentional harm – accidents (39)</td>
</tr>
<tr>
<td>6</td>
<td>Nephritis (89)</td>
<td>Alzheimer’s disease (27)</td>
</tr>
<tr>
<td>7</td>
<td>All accidents (72)</td>
<td>Diabetes mellitus (23)</td>
</tr>
<tr>
<td>8</td>
<td>Cancer and malignant tumors (64)</td>
<td>Nephritis, et al. (16)</td>
</tr>
<tr>
<td>9</td>
<td>Senility (50)</td>
<td>Influenza and pneumonia (16)</td>
</tr>
<tr>
<td>10</td>
<td>Diphtheria (40)</td>
<td>Intentional harm – suicide (12)</td>
</tr>
</tbody>
</table>

**Source**


Historical Policy and Medical Reforms

- FDR: the New Deal
- Harry S. Truman: Hill-Burton Act
- Lyndon Johnson: the Great Society - Medicare
- Richard M. Nixon: the National Health Strategy
- Ronald Reagan: the Prospective Payment System, COBRA
- Bill Clinton: the Health Security Act
- Barack Obama: the Affordable Care Act

Key Milestones:
- Insulin, 1921
- Penicillin, 1928
- Polio vaccine, 1952
- DNA, 1953
- Cancer Screenings, 1960–1970s
- Heart transplant, 1967
- MMR, 1971
- High-Tech Gene Therapy, 1990s...
10 Titles of the Affordable Care Act

I. Quality Affordable Health Care for All Americans
II. The Role of Public Programs
III. Improving the Quality and Efficiency of Health Care
IV. Prevention of Chronic Disease and Improving Public Health
V. Health Care Workforce
VI. Transparency and Program Integrity
VII. Improving Access to Innovative Medical Therapies
VIII. Community Living Assistance Services and Support Act (CLASS Act)
IX. Revenue Provisions
X. Reauthorization of the Indian Health Care Improvement Act

http://www.hhs.gov/healthcare/rights/law/
The Affordable Care Act: Shift in Focus

• A reform on the tax and payment systems developed to:
  ➢ Increase access to care
  ➢ Shift from process to outcome quality evaluation
  ➢ Shift from episodic to coordinated care for chronic diseases
  ➢ Increase prevention
  ➢ Provide care at the individual and population levels

• The Triple Aim
  ➢ Population health
  ➢ Quality and experience of care
  ➢ Lower cost per capita
What is Population Health?
Population Health

- Health outcomes for a group of individuals whom share at least one characteristic that influences their individual and collective health.
Why Do We Care?

Premise: If you improve the health status of people within a community, over time the health costs associated with caring for those people will stabilize or decrease.
Global Health Spending

Source: Organisation for Economic Co-operation and Development.
America Is Not Getting Good Value for Its Health Dollar

The U.S. spends more money per person on health than any other country, but our lives are shorter—by nearly four years—than expected based on health expenditures.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Sources: OECD Health Data 2007.
Does not include countries with populations smaller than 500,000. Data are for 2003.
*Per capita health expenditures in 2003 U.S. dollars, purchasing power parity
© 2008 Robert Wood Johnson Foundation
# United States: Shorter Lives, poorer health

## Comparative Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>Austria</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Norway</td>
</tr>
<tr>
<td>Australia</td>
<td>Netherlands</td>
</tr>
<tr>
<td>Italy</td>
<td>Germany</td>
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<tr>
<td>France</td>
<td>Finland</td>
</tr>
<tr>
<td>Spain</td>
<td>United Kingdom</td>
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<tr>
<td>Canada</td>
<td>Portugal</td>
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<tr>
<td>Sweden</td>
<td>Denmark</td>
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<tr>
<td>United States</td>
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<table>
<thead>
<tr>
<th>Death Rate per 100,000</th>
<th>United States Rank *</th>
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<tbody>
<tr>
<td>All causes</td>
<td>17/17</td>
</tr>
<tr>
<td>Non-communicable diseases</td>
<td>16/17</td>
</tr>
<tr>
<td>Injuries</td>
<td>16/17</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>12/17</td>
</tr>
</tbody>
</table>

* - 1 rank is the lowest death rate, 17 rank is the highest death rate.

Health Spending and Life Expectancy by Country

- **Low Cost — Long Life**
  - Japan
  - Italy
  - France
  - Canada
  - Sweden
  - Spain
  - UK
  - Germany
  - Austria
  - Netherlands

- **High Cost — Long Life**
  - Switzerland
  - Norway

- **Low Cost — Short Life**
  - US
  - Missouri

- **High Cost — Short Life**

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Health Expenditures Per Capita, 2011 World Bank

Health Expenditures Per Capita for Missouri is based on KFF data
Pay-for-Performance
Health Care Paradigm Shift

The Challenge Facing Hospitals

Volume-Based Old Curve
- Fee for Service
- Incentives Aligned with Quantity
- Little Financial Risk for Providers

Value-Based New Curve
- Incentives Aligned with Quality, VBP
- Shared Financial Risk for Providers
- Population Health Management
- Data-Driven Analytics & Decision Support

Decrease Cost
Increase Quality
### VBP Priority Weighting – FY 2017 on FR 24,508 and FY 2018 on FR 24,509

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Proposed 2018</th>
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<tbody>
<tr>
<td>Percent of Program Contribution</td>
<td>1.00%</td>
<td>1.25%</td>
<td>1.50%</td>
<td>1.75%</td>
<td>2.00%</td>
<td><strong>2.00%</strong></td>
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<tr>
<td>Process of Care</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
<td>Removed</td>
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<tr>
<td>Outcome</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
<td>25%</td>
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<tr>
<td>Patient Experience</td>
<td>30%</td>
<td>30%</td>
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<td>25%</td>
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<tr>
<td>Safety</td>
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<td>20%</td>
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<tr>
<td>Efficiency and Cost Reduction</td>
<td>20%</td>
<td>25%</td>
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## Pay for Quality Timeline

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<thead>
<tr>
<th>Reporting Program</th>
<th>FY 05</th>
<th>FY 06</th>
<th>FY 07</th>
<th>FY 08</th>
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<th>FY 10</th>
<th>FY 11</th>
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<th>FY 18</th>
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<td>Acute Inpatient PPS</td>
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<td>Inpatient Rehab PPS</td>
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<td>Long-term Care PPS</td>
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<td>Inpatient Psych PPS</td>
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<td>PPS-Exempt Cancer</td>
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<td>End-Stage Renal Disease PPS</td>
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<tr>
<td>Critical Access Hospital</td>
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- **MARKETBASKET UPDATE PENALTY**
- **MEDICARE PAY FOR PERFORMANCE VBP and HRRP**
- **MEDICARE PAY FOR PERFORMANCE HAC**

- Penalty based on data *submission*
- Penalty/bonus based on data *results*
Volume-to-Value
The Triple Aim

- Improve population health
- Improve experience and quality of care
- Lower per capita costs

Goal: Hospitals are highly reliable organizations that contribute to resilient communities.
Planning Assumptions

• The Triple Aim principles provide a rational approach to redesign
• Hospital transition will occur at different paces, sense of urgency and target dates
• No one domain is a stand-alone solution; all four domains must be interdependent
• Leaders must have the courage to innovate, accept risk and remain flexible
• Resource redistribution should be part of the strategy
Knowledge Management and Business Intelligence

Care Transformation

Engagement

Financial Alignment
Moving Upstream
MHA Triple Aim

Strategy by Design
Strategic Quality Guidance

- Strategic Quality Advisory Committee
  - Provides feedback and direction for quality improvement strategies

- Quality Improvement Workgroups
  - Readmission/Care Coordination
  - Clinical Excellence
MHA’s Quality Strategy

• Implement the Triple Aim

- Better Care
- Lower Costs
- Better Health
Strategic Quality Focus Evaluation

Community Health
- Health Outcomes
  - Mortality
  - Morbidity
- Health Factors
  - Behaviors
  - Access
  - Social and Economic Factors
  - Physical Environment

Care Coordination
- Manage Chronic Disease
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Hypertension
  - Diabetes
  - Congestive Heart Failure (CHF)
- Reduce Readmissions
  - Hospitalwide
  - Congestive Heart Failure (CHF)
  - Heart Attack (AMI)
  - Pneumonia
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Hip or Knee Replacement

Clinical Excellence
- Reduce Infections
  - Post-operative Sepsis
  - Catheter-associated UTI
  - Central line-Associated Blood Stream Infection
  - Clostridium difficile (C-diff)
  - Meticillin-resistant Staphylococcus Aureus (MRSA)
  - Surgical Site Infections – Colon
- Reduce Harm
  - Falls
  - Venous Thromboembolism
  - Mortality
  - Pressure Ulcers

Transparent measurement
Missouri hospitals are developing strategies to continue to increase the success of processes related to quality and patient safety outcomes. Our aim is to provide safe, timely, effective, efficient, equitable and patient-centered care for the Missouri communities we serve.

**CARE COORDINATION**

**MANAGEMENT OF DIABETES – UNCONTROLLED:** Diabetes is when your body does not make or use insulin well. Insulin is important because it turns the sugar in the foods you eat into energy for your body.

**MISSOURI RATE:** Between September 2013 and December 2014, approximately four out of every 100,000 patients were admitted to a hospital because of uncontrolled diabetes complications.

- Missouri hospitals decreased the rate for this measure 75% since the last reporting period.
- The Uncontrolled Diabetes Admission Rate is a national quality indicator that can be used to identify good community-based care.

**MISSOURI QUALITY – SNAPSHOT**

**JUNE 2015**

**CLINICAL EXCELLENCE**

- Missouri’s fall rate decreased almost 16% since the last reporting period.
- Each year, somewhere between 700,000 and 1 million people in the U.S. fall in a hospital.
- Missouri hospitals have worked diligently on fall prevention strategies including identifying patients at highest risk for injury from a fall, multifactorial assessments, consistent interventions and systematic reporting.

**MISSOURI RATE:** Fewer than 1 patient per 1,000 had a fall while in the hospital between January and December 2014.

**Focus on Hospitals**

Missouri hospitals – telling their own story ...
Community Health

- Socioeconomic (e.g. Racial, Income Inequities)
- Safety (e.g. Homicide Rate, Motor Vehicle Crash Death Rate)
- Health Behaviors (e.g. Smoking, Obesity, Binge Drinking)
- Health Care Access (e.g. Primary Care, Clinics)
- Preparedness

Common Goals

Hospital Utilization

- Preventable Hospitalizations (e.g. Diabetes, Asthma)
- Readmissions (e.g. CHF, COPD)
- Service Lines
- Health Care Access (e.g. Primary Care, Clinics)
- Other Factors...

Better Health...Better Care...Lower Costs
Align Strategies – Focused Approach

- Tertiary: Clinical management of patients and families
- Secondary: Targeted screenings for at-risk population
- Primary: Broad education and policy approaches

- Tertiary: Preventing complications
- Secondary: Preventing disease progression
- Primary: Preventing disease onset
Community Health

Hospital Utilization

COMMON GOALS

• Advocate
• Awareness
• Donate
• Champion

SOCIAL ISSUES

• Hotspot services
• Expand primary care
• Continuum of care services

PATIENT-BASED SERVICES

• Partner
• SME expertise
• Facilitate
• Develop
• Implement
• Evaluate

POPULATION-BASED STRATEGIES

BETTER HEALTH...BETTER CARE...LOWER COSTS
MHA Support
Technical and Adaptive
Technical Member Support

- Best practice resources
- Publications
- Toolkits
- Webinars
- Conferences
- Data collection and analysis
Adaptive Member Support

- Immersion projects
- Networking opportunities
- Regional workshops
- Best practice sharing
- External stakeholder engagement
- Collaborative engagement
Population Health Applied

Addressing Diabetes in the Kansas City Metropolitan Area
How to Comply: CHNA Guidance

1. Define the community
2. Identify partners
3. Gather available data
4. Seek community perspective
5. Aggregate data
6. Analyze and prioritize
7. Document and disseminate
8. Adopt and implement a plan to address issues
Definitions are provided for each condition

Raw data is available for download into MS Excel
Clinical Analysis of Diabetes in Kansas City EDs

ED Visits for Hypoglycemia

ED Visits for Hypoglycemia by Race/ Ethnicity

ED Visits for Hypoglycemia by Race/ Ethnicity (Males)

ED Visits for Hypoglycemia by Race/ Ethnicity (Females)

- Black or African American
- Hispanic or Latino
- White

[Graph showing trends over years]
Community Commons: CHNA.org

Diabetes Management by Year, 2008 through 2012
Percent of Medicare Beneficiaries with Diabetes with Annual Hemoglobin A1c Test

<table>
<thead>
<tr>
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</thead>
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<tr>
<td>Report Area</td>
<td>84.36</td>
<td>85.1</td>
<td>85.7</td>
<td>85.33</td>
<td>86.43</td>
</tr>
<tr>
<td>Clay County, MO</td>
<td>86.64</td>
<td>86.56</td>
<td>86.98</td>
<td>87.47</td>
<td>86.73</td>
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<td>Jackson County, MO</td>
<td>83.05</td>
<td>84.39</td>
<td>85.01</td>
<td>83.82</td>
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<tr>
<td>Johnson County, MO</td>
<td>84.29</td>
<td>85.27</td>
<td>86.68</td>
<td>85.62</td>
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<tr>
<td>Platte County, MO</td>
<td>88.14</td>
<td>87.16</td>
<td>87.02</td>
<td>89.06</td>
<td>88.2</td>
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<tr>
<td>Ray County, MO</td>
<td>82.47</td>
<td>81.41</td>
<td>83.38</td>
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<td>Missouri</td>
<td>83.02</td>
<td>84.45</td>
<td>85.1</td>
<td>85.51</td>
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<tr>
<td>United States</td>
<td>82.71</td>
<td>83.52</td>
<td>83.81</td>
<td>84.18</td>
<td>84.57</td>
</tr>
</tbody>
</table>

Diabetes Management by Year, 2008 through 2012

Report Area, Missouri, United States
Preventing Type 2 Diabetes :: Tools & Resources

Tools and Resources

**CDC Diabetes Prevention Health Communication and Marketing Materials**

- Resources from the NACDD State Diabetes Prevention Project
- Diabetes Prevention Resources and Tools from the National Diabetes Education Program

**CDC Diabetes Prevention Health Communication and Marketing Materials**

- Prediabetes Awareness
  - CDC Prediabetes Screening Test
  - Cuestionario de los CDC para la detección de la prediabetes
  - Prediabetes widget

- Employer
  - CDC Poster encouraging people to contact a local program
  - Business Case Talking Points for Employers/Insurers
  - Diabetes Prevention Program Return on Investment Abstracts

- General Public
  - CDC Poster encouraging people to contact a local program

http://www.chronicdisease.org/?NDPP_tools
Comprehensive Resources

CDC Prediabetes Screening Test

Could you have prediabetes?
Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease that can cause heart attack, stroke, blindness, kidney failure, or loss of feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.

Take the test—Know your score!
Answer these seven simple questions. For each "yes" answer, add the number of points listed. All "no" answers are 0 points.

- Are you a woman who has had a baby weighing more than 9 pounds at birth?
- Do you have a sister or brother with diabetes?
- Do you have a parent with diabetes?

Find your height on the chart. Do you weigh as much as or more than the weight listed for your height?

- Are you younger than 65 years of age and get little or no exercise in a typical day?
- Are you between 45 and 64 years of age?
- Are you 65 years of age or older?

Add your score and check the back of this page to see what it means.

AT-Risk weight chart

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>4'10&quot;</td>
<td>129</td>
<td>5'7&quot;</td>
<td>172</td>
</tr>
<tr>
<td>4'11&quot;</td>
<td>133</td>
<td>5'8&quot;</td>
<td>177</td>
</tr>
<tr>
<td>5'0&quot;</td>
<td>138</td>
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<tr>
<td>5'6&quot;</td>
<td>167</td>
<td>6'3&quot;</td>
<td>216</td>
</tr>
</tbody>
</table>

National Center for Chronic Disease Prevention and Health Promotion
Division of Diabetes Translation

If your score is 3 to 8 points
This means your risk is probably low for having prediabetes now. Keep your risk low. If you're overweight, lose weight. Be active most days, and don't use tobacco. Eat low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes.

If your score is 9 or more points
This means your risk is high for having prediabetes now. Please make an appointment with your health care provider soon.

How can I get tested for prediabetes?
Individual or group health insurance: See your health care provider. If you don't have a provider, ask your insurance company about providers who take your insurance. Deductibles and copays may apply.
Medicaid: See your health care provider. If you don't have a provider, contact a state Medicaid office or contact your local health department.
Medicare: See your health care provider. Medicare will pay the cost of testing if the provider has a reason for testing. If you don't have a provider, contact your local health department.
No insurance: Contact your local health department for more information about where you could be tested or call your local health clinic.

www.cdc.gov/diabetes
Healthcare Provider

- NEW American Medical Association and CDC: Preventing Type 2 Diabetes - A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program.
- CDC Poster encouraging people to contact a local program
- Information About The Lifestyle Change Program
- Recommendation Form
- Elevator speech
- Healthcare provider testimonial prompts
- Healthcare provider fact sheet
- Content for a mailing insert
- Outreach toolkit
- Talking points

National Diabetes Prevention Program

A Program to Help Your Patients Prevent Type 2 Diabetes

PREVENTING TYPE 2 DIABETES

A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program
Resilient Communities

- Establishing partnerships and networks
- Enhancing coordination
- Promoting physical, social and behavioral health
- Leveraging community and social systems
- Increasing access to information
- Empowering individuals

Resiliency refers to the ability to adapt to changing conditions and withstand and rapidly recover from disruption due to emergencies.

Contact Information

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