



MaineHealth

Population Health and the Triple Aim

Jackie Cawley, DO

January 21, 2010



Population Health: What is it?

Population Health

Definitions:

- The health, well being and functioning of a clearly defined population
- The health outcomes of a group of individuals, including the distribution of such outcomes within groups (Kindig and Stoddart, 2003)
- The capacity of people to adapt to, respond to and control life's challenges and changes (Frankish 1996)
- The social, economic and environmental factors that contribute to health of population

Population Health Approach

- Improve health of the entire population
- Reduce health inequities
- Look at and act upon a broad range of factors and conditions that have a strong influence on health
- Focuses on root causes
- Evidence based decision making and analysis
- Requires a variety of strategies and settings
- Recognizes the complex interactions and interplay between determinants of health
- Shared responsibility and accountability

Critical Success Factors

- Clearly defined Population (s)
- Health Information Systems to support data collection, analysis, reporting and exchange of information
- Defined areas of shared responsibility and accountability for providers and patients and their families
- Flexibility

Critical Success Factors

- Resources to develop interventions and programs for high impact areas
- Communication strategies for providers, patients and their families
- Innovative, interconnected strategies that consider the full spectrum of social, economic and environmental health determinants

Determinants of Health

The complex inter-relationships of

- Genetics
- Social environment
- Physical environment
- Behavior
- Access to health care services

That determine the level of health and sense of well-being of an individual

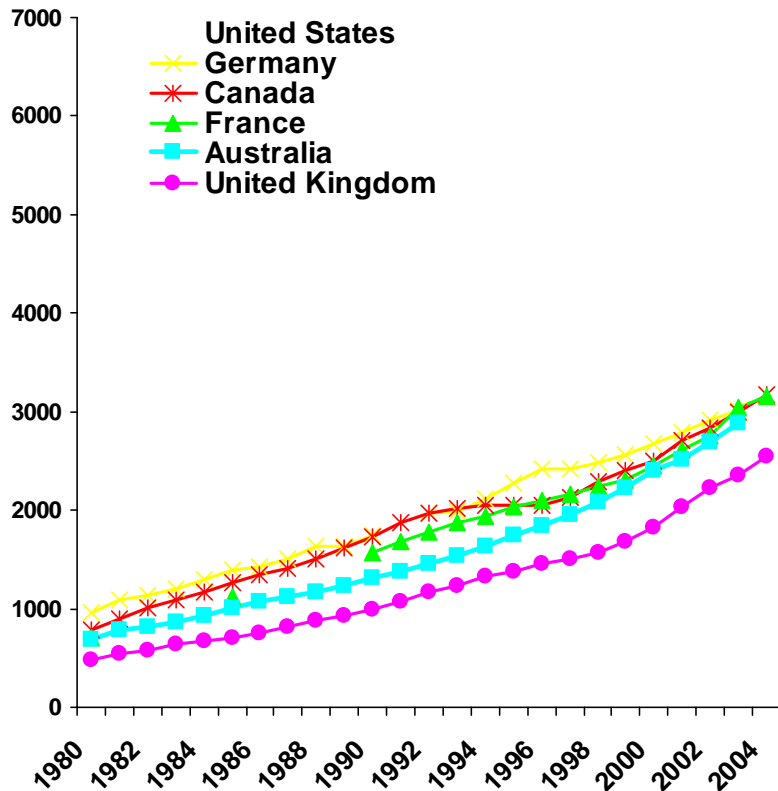
Determinants of Health and Their Contribution to Premature Death

- Behavioral Patterns 40%
- Genetic Predisposition 30%
- Social Circumstances 15%
- **Health Care 10%**
- Environmental Exposure 5%

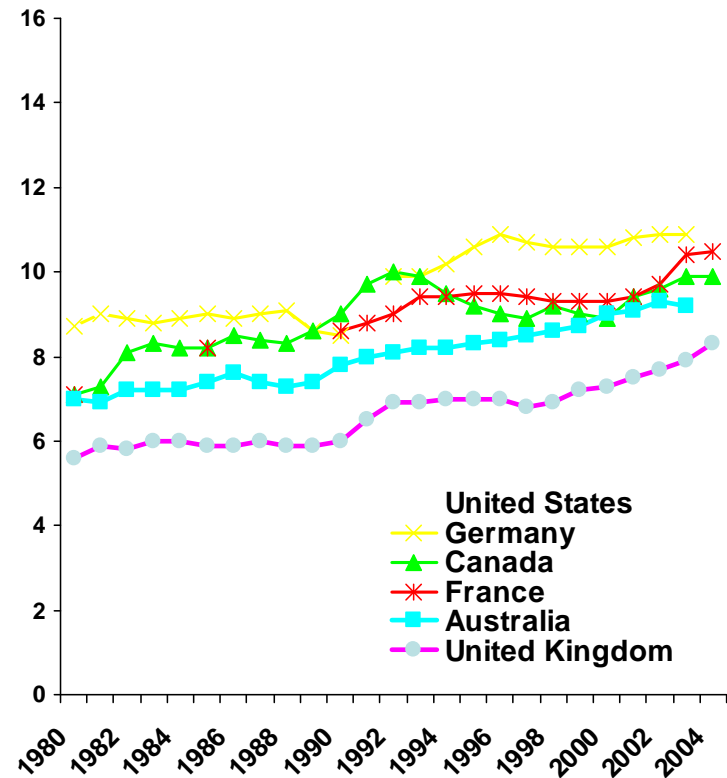
McGinnis et al

International Comparison of Spending on Health 1980–2004

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP



Data: OECD Health Data 2005 and 2006.

The US Health Care System

Patient Centered?

High Quality?



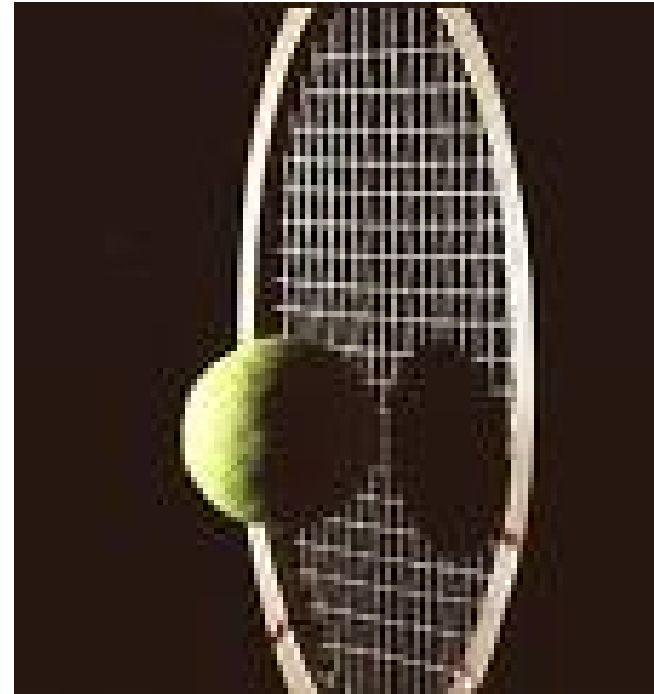
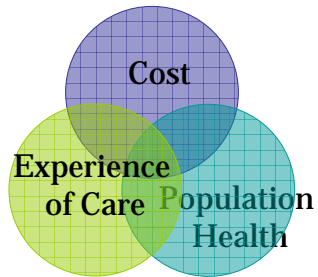
Patients
& Families

Cost Effective?

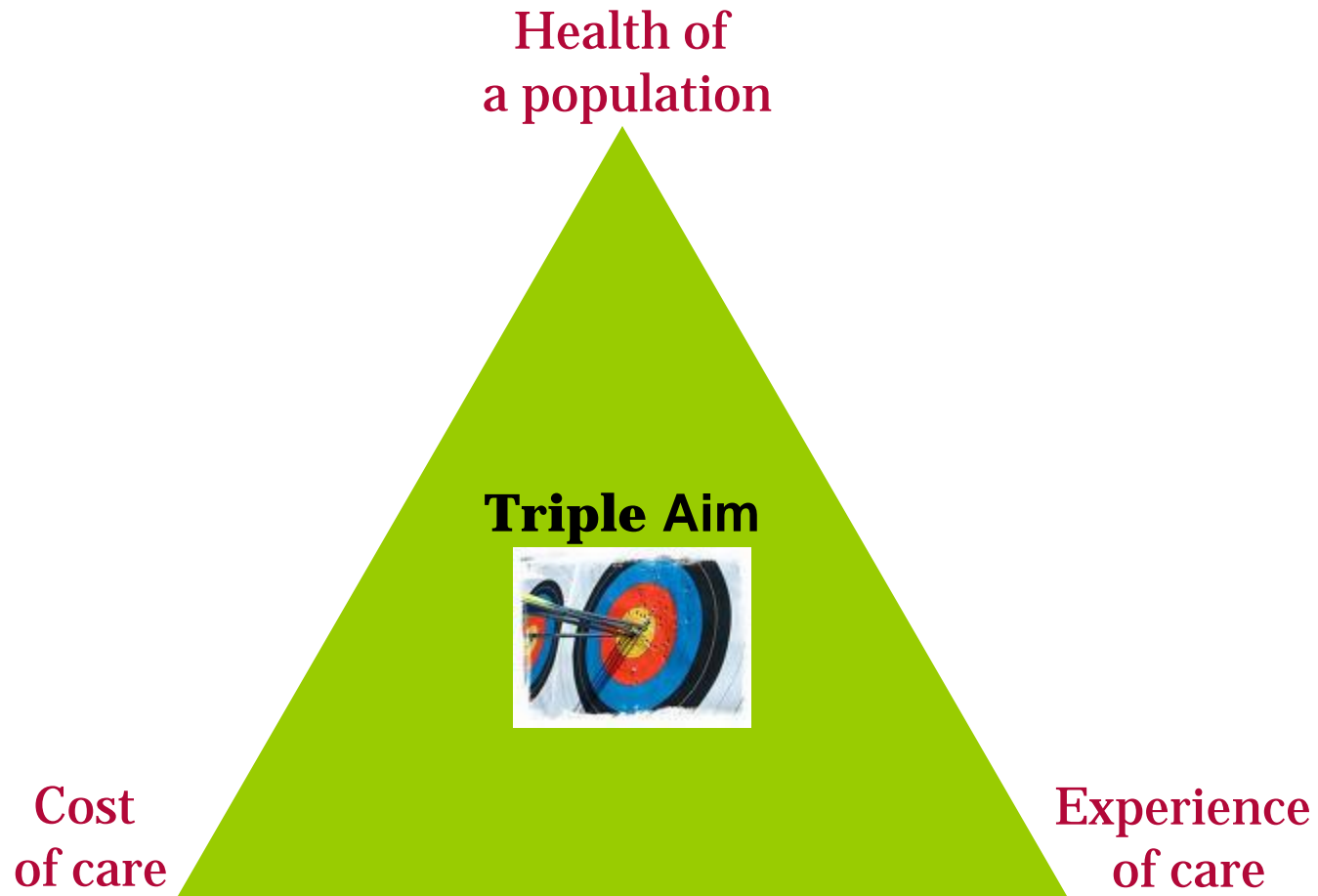
MaineHealth

What is the Triple Aim?

- The sweet spot



How do we improve health of *a population* in an efficient way while enhancing the *individual's* experience?



Triple Aim Design Components

1. Individuals and families
2. Redesign of “primary care” services and structures
3. Population health management
4. Cost control platform
5. System integration

1. Individuals and families

- For medically and socially complex patients establish partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among several providers of care
- Jointly plan and customize care at the level of the individual
- Actively learn from the patient and family to inform work for the population



- Enable individuals and families to better manage their own health

2. Redesign of “Primary Care” Services and Structures

- Have a team for basic services that can deliver 70% of the necessary medical and health related social services to the population



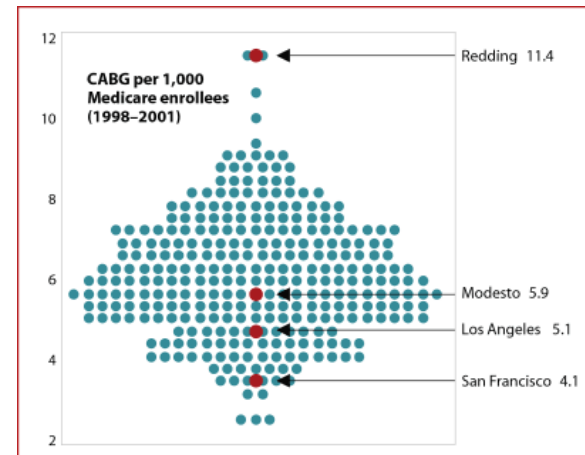
- Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families and provider



- Cooperate and coordinate with other specialties, hospitals and community services related to health

3. Population Health Management

- Efficiently customize services based on appropriate segmentation of the population
- Use predictive models and health risk assessments that take into account situational factors, medical history, and prior utilization to deploy resources to high risk individuals
- Work with the community to advocate and provide incentives for smoking prevention, healthy eating, exercise, and reduction of substance abuse. Provide assistance for all who wish to make health related behavior change
- Set and execute strategic initiatives related to reducing inequitable variation in outcomes or undesirable variation in clinical practice.



4. Cost Control Platform

- Achieve <3% inflation for per capita cost by developing cooperative relationships with physician groups and other health care organizations committed to reducing the waste of health resources
- Achieve lowest decile performance in the Dartmouth Atlas measures by breaking or countering incentives for supply-driven care
- Reward health care providers, hospitals, and health care systems for their contribution to producing better health for the population and not just producing more health care
- Orient care over time – the “patient journey” – targeted to the best outcomes

5. System Integration

- Match capacity and demand for health care and social services across suppliers
- Insure that strategic planning and execution with all suppliers including hospitals and physicians practices are informed by the needs of the population
- Develop a system for ongoing learning and improvement
- Institute a sustainable governance and financial structure for the Triple Aim system



MaineHealth

Learning Community

WELCOME TO THE

MainePHO

MaineHealth



MaineHealth

Who Can Do This?

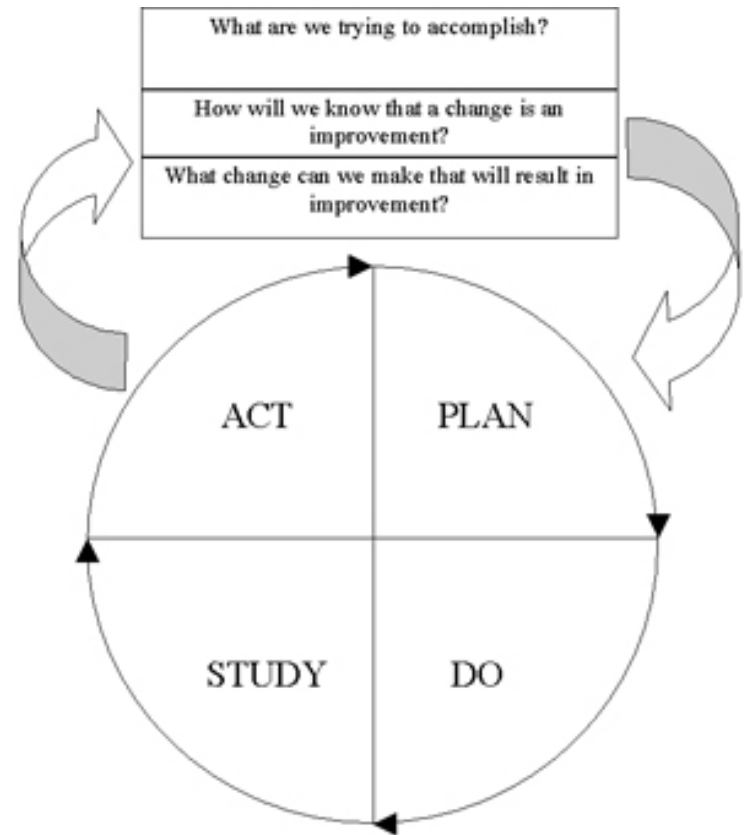
The Macro-Integrator

- May or may not be a new structure or organization
- Pulls together the resources to support a defined population
- Builds alliances and coalitions
- Optimizes the Triple Aim for the sake of a defined population
- Works with and helps to improve microsystems (practice teams) to support individuals

Ok, Get Real

How do you actually do this?

- Select a defined population
 - Known, stable (relatively), large enough to be meaningful, not focused on a specific disease or condition (generally)
- Select Aims/Measures
- Design elements that you can test (Logic model)
- Build coalition(s)
- Use individual cases to inform your work (What about Mary?)
- Adopt a model for improvement

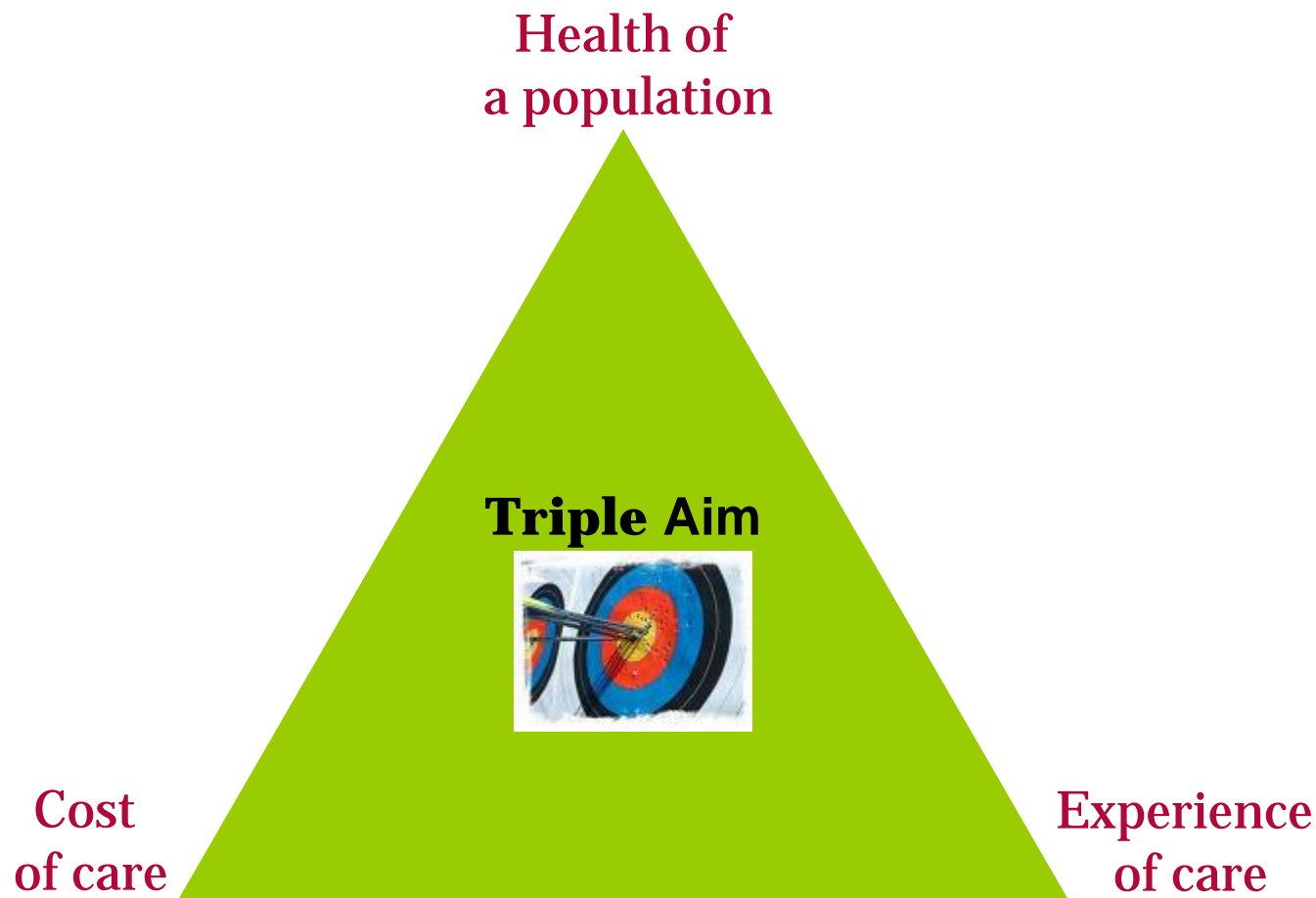


Who?

System of Improvement for the Triple Aim

- Level of ambition and consistency with organizational goals
- Methods to form coalitions
- System level measures to define the aim for a given population
- Themes or segments for guiding system changes
- Prototype testing beginning with the individual and family
- Scale up and spread
- Anchor the new approach in the community

How do we improve health of *a population* in an efficient way while enhancing the *individual's* experience?



The Fit?

- **PCMH**; personal physician, physician led team, whole person orientation, coordination of care, quality and safety, alternative scheduling/communication methods for patients, payment reform
- **PRISMs/ MHLIC**; Practice Redesign, Performance Improvement, Disease Management Programs, Preventive Health programs
- **PHO**; Patient Registry, Practice Coaching and Outreach, Reporting
- **MaineHealth**; Mission to improve the health of the communities it serves, Clinical Integration, Community Health Improvement
- **Individual practices**; PCMH pilots, participation, shared learning
- **Employer/payors**; Payment reform pilots, benefit design, Maine Health Management Coalition
- **Patients and Families**

The US Health Care System

Patient Centered?

High Quality?



Cost Effective?

MaineHealth



Questions?