Better Health and Lower Costs for Patients With Complex Needs

An IHI Triple Aim Collaborative

Informational Call
March 31, 2015
Goals Of Call Today

- Answer your questions about the Better Health and Lower Costs for Patients With Complex Needs Collaborative
- Describe the IHI methods and content to be used in the Collaborative
- Describe the activities of the Collaborative
BHLC: A Triple Aim Initiative

**The Triple Aim** is a guiding concept to simultaneously improve three dimensions:

- Improve the health of the populations;
- Improve the patient experience of care (including quality and satisfaction);
- and
- Reduce the per capita cost of health care

**BHLC Collaborative** will help you:

- Redesign and implement comprehensive care designs to serve your patients with complex needs (who are at high risk of driving high costs in the future)
- Establish measures and build a portfolio that will result in better health outcomes, a better care experience, and lower total cost
- *Whether your organization has already established a program or is just starting this work*, our goal is to help you make a positive and sustainable difference for this population
Why This, Why Now?

Why Focus On Patients With Complex Needs whose Care is Costly?
Why Now?
Triple Aim High Risk, High Cost Workgroup and Year 1 BHLC
Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditure, 2009

Source: Agency for Healthcare Research and Quality - analysis of 2009 Medical Expenditure Panel Survey
On average, healthcare spending is highly concentrated, with the top 5% of the population (ranked by cost) accounting for the 60% of expenditure.
Persistence in Spending

Figure 1. Persistence in the level of health care expenditures, U.S. civilian noninstitutionalized population, 2008 to 2009

Managing Services for a Population

Community, Family and Individual Resources

Needs Assessment for Segment → Goals → Coordination → Delivery of Services at Scale

Population Segmentation → Integrator

Population Outcomes

Feedback Loops
Guiding Principles

1. Identification of individuals at high risk for future cost
2. Impactability of the identified individuals
3. Cost effectiveness of your intervention or redesign – must understand the cost drivers in your population and region
4. Potential interventions or redesign – what we are currently doing isn’t working, so how can we change it?
5. Build your program to reach all who will benefit - plan for financial and operational sustainability
Roadmap

Choose your macro population and learn its segments
Identify individuals who are good candidates for your enhanced care design
Develop a care model to fit the needs and strengths of the target population
Recruit people into care
Engage people in care
Partner within and outside of your organization

Learn to operate sustainably at full scale: 5 to 25 then 5x
Collaborative Faculty

Cory Sevin  
*IHI Director*

Catherine Craig  
*Faculty*

Kevin Nolan  
*Improvement Advisor*

Alan Glaseroff  
*Faculty*

Ann Lindsay  
*Faculty*

Eleni Carr  
*Faculty*
Hospital Utilization Rates for HRP cohort

- **n= 424** clients engaged in program on or before 9/1/13

**non-OB Inpt Stays PMPY**

- 12 mos PRE: 1.7 PMPY
- 4+ mos POST: 1.1 PMPY
- 35% ↓

---

Rate per Member Per Year

- Median
ED Utilization Rates for HRP cohort

ED Visits - PMPY

n= 424 clients engaged in program on or before 9/1/13

12 mos PRE: 8.5 PMPY
4+ mos POST: 5.6 PMPY
34% ↓

Median
# Triple Aim Results - Stanford Coordinated Care

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>ER Visits</th>
<th>Patient Experience</th>
<th>HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>-25%</td>
<td>-39%</td>
<td>99&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>&gt;90&lt;sup&gt;th&lt;/sup&gt; percentile</td>
</tr>
</tbody>
</table>

271 patients with at least 6 months enrollment

Used with Permission from SCC
Learning Collaborative

- 12 month Learning collaborative beginning July 2015
- 30-40 organizations
- 3 Learning sessions, one will be face-to-face
- Two core tracks with monthly webinar sessions
  - Foundations of Care Redesign
  - Scale-up and Sustainability
- Additional tracks to support your work
  - Leadership
  - Measurement
- Use of QI methods and rapid, iterative learning

*All Teach, All Learn*
Track 1: Foundations of Care Redesign

Goals within 12 months:

- Identify a specific high-risk population that will be the focus of your work
- Deeply understand the assets and needs of your target population to inform the services needed to improve outcomes
- Develop and execute new care designs to test for impact and cost savings
- Increase the scale and reach of successful care designs
- Learn what is needed for operational and financial sustainability
- Establish process and outcome measures to use available data to track health, patient experience, and cost savings
Track 2: Scale-up and Sustainability

Goals within 12 months:

- Achieve scale-up of enhanced care designs and approach full scale, i.e., reach all individuals who would benefit from the care model.
- Develop reliable work processes to support effective delivery of enhanced care to the target population at scale.
- Develop robust learning systems during scale-up to support operationally and financially sustainable enhanced care programs for the target population.
- Demonstrate positive outcomes in at least two of the three prongs of the Triple Aim: health outcomes, patient experience, and costs.
Who Should Participate?

Organizations that provide (or plan to provide) care for defined population groups while bearing the financial risk of caring for those groups will benefit from participation in this learning community.
Participants May Include

• Integrated systems of health delivery and financing operating anywhere in the world

• Accountable Care Organizations (ACOs) or integrated delivery systems that are pursuing other new payment models

• Physician group ACOs

• Private or publicly funded health plans committed to improving value

• Primary care or multi-specialty physician groups interested in risk sharing and cost savings arrangements

• Organizations embarking on innovative, population-focused designs

• Safety-net health care systems facing rising demands and flat budgets

• Regional coalitions collaborating on a community-wide health issue or working to ensure access for all while controlling costs

• Public health departments or social agencies focused on populations with complex health issues

• Private or public employers seeking better health and value for employees
Questions and Discussion
Impacting Outcomes and Costs for Patients with Complex Needs Seminar

- April 23rd – April 24th
- Denver, CO
- Visit ihi.org for seminar agenda, faculty information and hotel/ travel information
- Contact Meghan Hassinger (mhassinger@ihi.org) with any questions
July 2015

“Better Health and Lower Costs for Patients with Complex Needs-Year 2
An IHI Triple Aim Offering”

Contact:
BetterHealthLowerCosts@IHI.org