

Health Systems Transformation Team

AGENDA

Wednesday, February 9th, 2011
Willamette University
Putnam University Center, Cafeteria
6:00 pm to 9:00 pm

#	Time	Item	Presenter
1	6:00	Welcome and introductions	Bruce Goldberg, Mike Bonetto
2	6:10	Summary of break out sessions from February 2 nd Prioritized ideas and next steps	Bruce Goldberg
3	6:30	Innovative models of accountability for the health of a population	Judy Mohr Peterson
4	7:00	Breakout Sessions Innovative models of accountability for the health of a population Consumer scenarios Questions: If an organization was accountable for the health and health care financing of a defined population: 1. How would it look different for the consumer? 2. What would your community need to do differently? What would be the key components?	Diana Bianco and facilitators
5	8:15	Summary: Breakout groups report back	Diana Bianco
6	8:55	Closing remarks and notes on next week	Mike Bonetto, Bruce Goldberg

Next Meeting:

Wednesday, February 16th, 2011; 6:00 – 9:00 PM.

**Labor and Industries Building
Conference Room 260
350 Winter Street NE
Salem, OR 97301**

Health System Transformation Team
Minutes
February 2, 2011
Willamette University
Putnam University Center
6:00 PM to 9:00 PM

Item

Governor's welcome and opening remarks (6:07 PM)

Co-chair Dr. Bruce Goldberg opened the first meeting of the Health System Transformation Team, with the Governor's Health Policy Advisor, Mike Bonetto, co-chairing. Eileen Brady joined by phone and Terry Coplin was absent. The facilitator for these meetings is Diana Bianco of Artemis Consulting.

Governor Kitzhaber began the meeting with his opening remarks:

- We are not gathered to study the problem – we know the problem. “We have a medical system that is too expensive, it's too inflationary, and we can't afford anymore. And it's not producing the outcomes that we ought to be getting.”
- The challenge is twofold: In the first year, we must reduce costs to stay within a budget. But this is also an opportunity to redesign the system starting in the second year of the biennium and going forward from there.
- “Your responsibility, it seems to me, is to figure out what that new delivery model looks like even while we maintain the old model for the first year. That's like changing the tire on a Volkswagen while you're driving down I-5, I appreciate that. But if there's any group of people that can make that happen, it's people right here in the state of Oregon.”
- On the issue of federal waivers: There's a desire within the federal government for a state, or several states, to demonstrate that the federal health care reform is not only about expanding coverage, but can also be a fulcrum for fundamental delivery system reform. There is a willingness to put the effort into working with the states on system reform ideas.

Review: (6:34)

Mike Bonetto reviewed the Team's [Charter](#) and [Work Plan](#).

- This Team was chartered by, and is working under, the auspice of the Oregon Health Policy Board (OHPB), and it reports back to the Board and the Governor. This Team's work is an extension of the OHPB's *Action Plan for Health*.
- All meetings are open to the public. There is also a public input mechanism through our website.
- Specific work products that we expect from this process are: **Elements for successful delivery system transformation**. What are the key elements in terms of the state moving forward and engaging new delivery systems? What needs to be a part of that and how can we put those pieces in place?
- **Will these changes have the desired impact on the budget?**
- **Legislation:** Once we have a clear plan and a vision for a system that we want to reach, we need to then work backwards and think about what we need to do legislatively, both at a state and federal level in terms of waivers, to make our plan operational.

This Team has a very tight timeframe for moving through a substantial amount of work. The beginning of April is a deadline for having a work product to turn over to the legislature.

Dr. Goldberg emphasized again that this Team has a clear timeline, clear deliverables, and a clear endpoint.

Diana Bianco explained the idea of “working meetings.” Each meeting will follow a similar pattern:

- There will first be information supplied to the group (today, for example, we will be seeing a presentation about redesigning the delivery system within a budget constraint).
- The Team will break out into small assigned discussion groups. Each group will have a facilitator and scribe. The group discussions will last for about an hour and will cover the topics and questions for that week.
- Then we will reconvene as a large group to go over some of the best ideas that were discussed at the break out tables.
- The next week we will come back and have another topic that we will tackle in a similar fashion, but we will also hear about a lot of the work that has been done between meetings, and some of the progress made on discussion topics of past weeks.
- We think this is how we can use all of your time as effectively as possible.
- Public input will also be folded into our work.

The question was raised as to whether this is meant to be a consensus process as well as a design process. The answer remains to be seen, but the group will strive for consensus in most cases. The expectation is that there will be difficult conversations, trade-offs, and challenges, and we may surprise ourselves in finding consensus where we thought there may have been none. There will be no voting during this process.

Redesigning our delivery system and budgetary constraints (6:54)

Dr. Goldberg presented a power point on the budget situation currently facing the state of Oregon.

- Expenditures are growing at a far greater rate than revenues.
- We are going to consider the Oregon Health Plan budget and the long term care budget as the dollars that we have to work with to create this system. That is 2/3 of the general fund dollars that go into health care in this state.
- Amount we need to make up with reductions in provider payments & provider benefits combined with the substantive system redesign is about \$850 million (slides 18 and 19).
- Our vision is to restructure our health care delivery system to deliver better health, better health care and lower costs (Triple Aim).
- We must align incentives and increase accountability.

The presentation can be found [here](#).

Breakout Sessions (7:30)

Ms. Bianco organized the break out session. Groups were assigned to answer the following questions:

1. What ideas do you have to manage within the cuts proposed in Year 1 and at the same time preserve access and quality? Are there better alternatives for attaining the necessary savings?
2. What will be needed to be successful?

Summary: Breakout groups report back (8:20)

The Team reconvened as a group to discuss some of the ideas, issues, and options that were raised during the breakout sessions. A summary of the options with some estimates of savings will be brought back to the group at the 2/9/11 session.

The summary of the break out sessions can be found [here](#).

Closing remarks and notes on next week (8:55)

The Team will move forward quickly, starting next week, and will continue to work through this problem.

Everyone was encouraged to think about year two over the next week and to come prepared to talk next Wednesday.

Adjourn (9:00 PM)**Next meeting:**

February 9, 2011

Willamette University

Putnam University Center

6:00 PM to 9:00 PM

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February 2, 2011

Options for Year 1 of 2011-2013 budget

Small group break out summary

Ideas and options for year 1

- ***Address Medicaid population in all regions of the state by bringing together community partners, local plans and provider networks*** to explore rapid approaches to decrease ED utilization and unnecessary hospital admissions. Could be first step toward the type of collaboration necessary for Yr 2 and onward to sustainable costs within accountable communities. Initial focus should be on the high utilizers in the region.
Next Steps: OHA will call together stakeholders to discuss potential approaches to align efforts that can be rapidly deployed for Year 1. Host “regional opportunity conferences.”
- ***Relief from regulatory requirements that contribute to administrative costs for plans and providers.*** Many recommended looking especially at behavioral health contract requirements as a source of significant load for plans and providers.
Next steps: OHA staff will seek input from stakeholders to delineate statutory and regulatory that have the most potential to yield immediate savings while not reducing accountability, identify how savings are attained (reduced FTE, administrative costs, etc). A template for collecting this information is attached.

Options included in Governor’s Balanced Budget

- ***Eliminate payments for marginally effective treatments based on evidence:*** The last 30-40 items on the Prioritized List of Health Services are prioritized to the bottom of the list because they have been determined by evidence to be marginally effective. (*Estimated savings: \$29.1m GF, \$80.5m TF*).

Next steps: OHA staff is examining other funded lines, as directed by the Oregon Health Policy Board’s Action Plan, in consultation with the Center for Evidence-Based Policy. Ten common clinical guidelines are being developed with stakeholders and will be applied to Year 2 savings. The intent of this option is to eliminate or severely limit marginally effective tests and treatments for conditions that will remain above the line, by the use of evidence based decisions. For example:

- back surgery for radiculopathy is covered and will likely remain above the line, but there are several treatments, some of which are marginally effective and some of which are quite effective.
- imaging for back pain is currently covered as a "line 0" expense and will continue to be covered, but has been shown (by OHSU) to be marginally or not effective
- treating high cholesterol will be above the line, but statin therapy for those without other risk factors is expensive and only marginally effective.
- Treatment of cancer is above the line, but some of the second and third tier therapies are very expensive and either not effective or only marginally effective.

- Some of the preventive care we do is not evidence based (e.g., PSA's)- we should only be doing that which is evidence based.
- **Eliminate payments for never-events and healthcare acquired conditions:** Following Medicare definitions. *(Estimated savings in FFS for health care acquired conditions: \$0.04m GF, \$0.21m TF).*

Next steps: OHA staff to estimate savings from eliminating payment for never events in nursing facilities and from reducing payment for hospital readmissions. Current pricing includes FFS only so staff will develop pricing for Medicaid managed care as well. Continue analysis of potentially avoidable complications (PAC) to develop payment approaches.

Options that rapidly implemented and may yield savings in Year 1:

- **Further restrict allowable DME so that they equal the rate reductions being proposed –** This could be a means for plans and other providers to reduce their costs.
Next steps: Staff review needed rules, statute or CMS changes and calculate potential savings. *(Estimated savings: equivalent to rate reductions being proposed?).*
- **Restructure of dental benefit more to align with commercial benefit design to include limits on expenditures.** This could be a means for dental plans to operate within their rate reductions. *(Estimated savings: equivalent to rate reductions being proposed?).*
Next steps: Dental plans and provider experts to determine benefit redesign and bring back to the team.
- **Tighten restrictions on prescribing brand name drugs where good generic options are available.**
 - Increasing restrictions on brand name drugs is a benefit restriction that would allow plans to operate within their rate reductions. *(Estimated savings: TBD)*
 - Making the Medicaid preferred drug list (PDL) enforceable is included in the Governor's balanced budget. *(Estimated savings: \$6.4m GF, \$17.8 TF)*
 - HB 2009 directed the development of a statewide PDL; savings potential from adoption of that PDL is currently being estimated. *(Estimated savings: TBD)***Note:** Generic use within Medicaid is currently at 85%, so opportunity may be limited.
- **Change payment to incent primary care homes and enhanced care coordination.**
 - *Implement patient-centered primary care homes to enhance care coordination.* This would shift care from more expensive areas to less expensive areas, better integration of behavioral health with physical health, focus efforts for optimal prevention and chronic disease management and aligned with the Policy Board's *Action Plan for Health*. Community mental health clinics were highlighted as an important location to include as a primary care home for some populations.
Next steps: Significant work is underway within OHA but stakeholders will need to be involved in implementation planning to ensure efficient and timely implementation. Concerns over rate reductions undermining primary care access

could be mitigated by holding primary care at current rates for providers implementing primary care home models. (*Estimated savings: TBD*).

- *Initiate broad use of DRG methodology for inpatient care, APCs for outpatient.* This is part of the Policy Board’s Action Plan, as recommended by its Health Incentives and Outcomes Committee. This shift would lead to standardization of payment and provide a uniform base upon which to build further payment reform focused on performance and payments such as bundled payments that can discourage fragmented care.

Next Steps: Work with stakeholders to implement and develop contracting language. (*Estimated savings for changing payment to DRG hospitals to Medicare methodology in both managed care and FFS: \$5.72m GF, \$20.72m TF*). *Estimated savings form changing to APCs for inpatient care: TBD.*

- **A new model of care for “open card”/FFS portion of OHP** – The most significant group of Medicaid beneficiaries not currently enrolled in managed care are the “dual eligibles.” There is real potential for improving population health (including access to appropriate services), enhancing patient experience, and reducing the cost of services for this population. Examine the top 20% of utilizers and move into primary care homes within 6 months. (*Estimated savings: TBD*)
Next Steps: Apply for a waiver of Medicaid rules to move this population into a managed care setting.

Options presented in small groups, but not identified as “Top Two”

- **Continue to explore efforts to pay for enhanced care coordination and effective care:** Go beyond the primary care home to work with hospital, specialty, dental, behavioral and long-term care providers to focus on reducing ED visits and hospital readmissions. This could include:
 - *Increase co-location or virtual relationships of providers to partner with others*
 - *Focus efforts on the 20% of the population that is driving 80% of the costs*
 - *Increase efforts to pay for effective treatments, target services growing rapidly without a solid evidence base and tie to an “essential benefit package”*
 - *Work to lower barriers that prevent care providers from working together such as anti-trust, concerns with risk, and challenges in the negotiation processes.*
 - *Focus on restructuring care in LTC to provide resources on site to avoid need for expensive transfer to ED or hospital setting, especially evenings and weekends.*
- **Augment and build primary care workforce capacity:** Explore ways to use dentists and other non-physical health focused providers to partner with physical health providers to identify and assist monitoring of chronic diseases such as diabetes while also enhancing Oregon’s primary care workforce. Peer counseling as used in some mental health and

substance abuse settings, patient navigators and community health workers were highlighted as examples of effective community partners with clinically-focused health providers and facilities.

- ***Develop metrics needed to reach budget goals and hold plans and providers accountable.*** Each community may have different drivers, so metrics will need to allow for future accountable care organizations to target their combined resources to address their local cost drivers.
- Need to include PEBB and OEBC in these efforts to drive costs down and improve care coordination in state employee and school district populations.

Regulatory Barriers to Efficiency

Organization Type: _____
(e.g., hospital, clinic, mco, snf, etc)

Statute/Regulation	Estimated annual cost of implementing	Alternative recommended practice

After completing, please return to Tina Edlund at tina.d.edlund@state.or.us

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Health System Transformation Team

February 9, 2011

Toward a Vision for Accountable
Health In Oregon



Purpose of the presentation

This presentation will offer some examples of health care innovation

- To catalyze our thinking – not to offer all the answers
- To help us identify the essential elements for a successful Oregon model of accountable integrated care and services



Essential elements for pursuing the Triple Aim*

- Target population
- Capped total spending with strict year-over-year budget targets
- "Integrator" that accepts responsibility for all components of the Triple Aim – improving population health, improving the experience of care (quality), and reducing per capita cost
 - Delivering person-centered care and services
 - Redesigning care: strengthening primary care and improving coordination between primary and specialty providers and community supports
 - Targeting the needs of particular subpopulations
 - Driving annual initiatives to reduce waste
 - Paying providers and allocating resources to support Triple Aim goals
 - Budgeting cautiously for capital investment (e.g., technology & infrastructure)
 - Monitoring performance using evidence-based quality & cost measures
 - Using provider agreements that align incentives to support the Triple Aim

*Extracted from materials of the Institute for Healthcare Improvement



Let's Try it Out Using Some Real-World Examples...

- PACE - full integration of Medicare/Medicaid/LTC services for a select population of voluntary enrollees
- Minnesota Senior Health Options Program - full integration of Medicare/ Medicaid/LTC services in a managed care model for all enrollees in pilot counties
- Arizona Long-Term Care System (ALTCS) – full integration of Medicaid health and LTC services in a managed care model for all enrollees
- Geisinger Health System –collaborative, cross-silo system improvement efforts with supporting provider payment systems
- Jonkoping, Sweden – regional government responsibility for all aspects of health care services for an entire community of 330,000
- Grand Junction community effort – community collaborative involving most providers and major plans



PACE – The Program for All-Inclusive Care for the Elderly

- Sponsored by Medicare – A program built on the OnLok model developed in San Francisco's Chinatown
- Target population: Medicare beneficiaries with need for nursing facility level of care who choose a PACE plan
- Plans receive both Medicare and Medicaid capitation payments to provide all health and long-term care support and services, including prescription drugs
- PACE plans must follow a prescribed model of care delivery
 - Team approach to care and service planning with individualized service plans
 - Non-institutional living arrangements
 - Day center-based services, including nurse and physician, therapy, meals, and recreation
 - Support services, including services not covered by traditional Medicare and Medicaid programs



Results from PACE programs

- Experience of care (compared to traditional home & community-based services)
 - Higher rates of preventive care
 - Lower rates of difficulties with pain, activities of daily living
 - Higher rates of life satisfaction
 - Lower rates of hospitalization
- Cost - Savings expectations have been neither demonstrated nor refuted
- Population health
 - No demonstrated difference in health status for enrollees
 - Does not address health of non-enrollee except to the extent it facilitates caring for frail elderly in a way that supports families
- Growth - The model has grown slowly.



Minnesota Senior Health Options

- Pilot sponsored by Minnesota Medicaid and CMS, beginning in 1997
- Target population: Persons eligible for Medicare and Medicaid health, especially those needing long-term care services
- Plans receive both Medicare and Medicaid capitation payments to provide all Medicare and Medicaid services – 17 plans in 7 counties
- Plans must provide care coordination
- Plans must develop a person-centered plan for each long-term care eligible beneficiary
- Plans contract for the array of services, using sub-capitation in some cases
- State and plans collaborate on quality assurance and performance improvement, use of chronic care protocols, and developing best practices and encouraging their use for providers



Results of Minnesota Senior Options Pilot

- Experience of care
 - Improved patient/family satisfaction especially for nursing home population
- Cost
 - Not available.
- Population health
 - No significant difference in health status has been demonstrated between pilot population and a comparable population
 - Program does not address broader community health issues



Arizona Long Term Care System (ALTCS)

- Sponsored by Arizona Medicaid, which has contracted with plans to provide both long-term care and health services since the state Medicaid program began in 1989
- Target population: Medicaid eligibles at risk for institutionalization
- Managed care plans provide all Medicaid-provided physical health and long-term care services for the target population (behavioral health is carved out)
- Medicaid Managed care participation is mandatory
- Medicare Managed care participation is voluntary, but many beneficiaries choose Medicare plans operated by ALTCS contractors
- Managed care plans must develop individual care plans



Results of ALTCS

- Experience of care
 - High participant satisfaction
 - Highest rate of non-institutional care of individuals with nursing home level of need in the country
 - Difficult to measure quality of health services because there is no Arizona comparison group
- Cost
 - Early studies showed Arizona's Medicaid long-term care population had lower rates of utilization of acute care services (except for Evaluation and Management services) than a comparable New Mexico population
 - Early studies showed Arizona's LTC population in nursing homes used fewer acute care services than those in home & community based services
- Population health
 - Unknown



Other states are experimenting with integration of health and long-term care services

These include:

- Tennessee
- Wisconsin
- Washington (Snohomish Co. pilot)



Geisinger Health System

- Sponsored by Geisinger Health System, an integrated delivery system that serves individuals enrolled in its own health plan as well as others (more like Providence than Kaiser)
- Target population: Primarily commercial
- Strategies:
 - Primary Care Home initiative
 - Enrollees with chronic conditions have a primary care home and personal health navigator
 - Providers develop bundles of care for chronic conditions
 - Up to 20% of provider payment is at risk for compliance with best practices and patient satisfaction
 - ProvenCare Acute Care initiative
 - Bundled payments go to clinical groups for acute episodes (guarantee: no additional charges for 90 day period)
 - Providers develop best practice elements of care to improve quality
 - Patient agrees to take steps to improve care
- Supported by a strong electronic health record system



Geisinger Results

- Experience of care
 - Coronary Artery Bypass Graft (CABG): Increased adherence to best practices increased from 59% to 100%, complications reduced by 8%, and readmissions reduced by about 50%
 - Primary care home: Reduced admissions by 20%, improved outcomes
- Cost
 - Primary care home: 7% over-all cost savings
- Population health
 - Not measured broadly although control of diabetes improved
 - No responsibility for community as a whole
- Next steps
 - Goal is to bundle 50% of all services as flat-rate packages



Jonkoping, Sweden

- Sponsored by county of Jonkoping, Sweden (population 330,000)
- Since 1982, Sweden has assigned responsibility for providing health care (including dental and public health) to its counties, which levy taxes and fix budgets for health care
- Goals: patient-centered, evidence-based, effective, efficient, safe, and equal
- Strategies:
 - Three geographic units are given a population and a budget
 - Each unit has an anchor hospital and primary care centers
 - Quality improvement efforts are addressed to broad issues of access, collaboration, clinical processes, patient safety, and medication
 - Quality Improvement projects address specific issues targeted for improvement such as nutrition for the elderly; care coordination and integration of services for the elderly; preventing falls, ulcers, and pain; and eliminating waits for visits.
 - Performance is measured at all levels. Measures include cost, clinical outcomes (C-section rates, recovery from stroke, readmissions, patient satisfaction), and financial performance



Jonkoping Results

- Experience of care
 - Reduced rate of hospital admissions for pediatric asthma from 20 to 7 per 10,000 with pediatric asthma (compared to 30 in the US)
 - Reduced wait times for primary and specialty care appointments and telephone consultations
 - Reduced hospital admissions for the elderly by 20%
 - Reduced hospital days for heart failure by 30%
 - Best quality in Sweden by far on a composite index including measures of access (eg., 7-day access, number of visits), quality (readmissions, depression after stroke, C-section utilization), and cost (per capita cost)
- Cost
 - Lower per capita cost than the average in Sweden
- Population health
 - Higher rates of psychological well-being than Swedish average



Grand Junction, Colorado

- Sponsored by a community collaborative that involves an IPA with 85% of the region's physicians, the single dominant hospital, a safety net clinic, HMO, and social service providers
- Target population: Entire community
- Goals:
 - Improve primary care and coordination of care
 - Limit supply and use of expensive resources
- Strategies:
 - Providers share responsibility for Medicare, Medicaid, and commercial patients
 - Physician peer review using plan data
 - Health information exchange
 - Collaborative efforts to address issues like low birth weight babies, chronic disease, end of life care
 - HMO puts 15% of provider payment at risk for cost and quality performance



Grand Junction Results

- Patient Experience of Care
 - Hospital scores in the top 10% for quality
 - Fewer hospitalizations, shorter hospitalizations, and lower hospital mortality
 - Population spends 40% less time in the hospital during the last six months of life than the national average
- Cost
 - Medicare cost substantially below national average in all categories except outpatient physician care, which is average
- Population
 - County as a whole ranks #1 in Colorado on clinical care indicators in RWJF's County Health Rankings (% uninsured, primary care provider rate, preventable hospitalizations, diabetes screenings, and hospice use)



What can we learn?

- Targeting a population
 - Jonkoping and Grand Junction focus on an entire community, which encourages public health approaches and a focus on equity and social services supports
 - PACE focuses on fragile elderly, thinking about all of their needs
 - Geisinger targets a subset of patients that are high needs/high cost
- Capping total spending with strict year-over-year budget targets
 - Jonkoping, PACE, Minnesota pilot, and ALTCS MCOs all operate on fixed budgets
 - Jonkoping's budget is set by community leaders whereas PACE, ALTCS, and Minnesota pilot rates are linked to Medicare and Medicaid capitation rates
 - Geisinger's bundled payment system encourages elimination of preventable complications (costs related to defects in care) but fails to address technology-driven utilization or price of care to the purchaser



What we can learn?

- “Integrator” that accepts responsibility for all components of the Triple Aim – improving population health, improving the experience of care (quality), and reducing per capita cost
 - Only Jonkoping has a powerful integrator
 - Patient-centered care and services – Geisinger, PACE, and Jonkoping all focus new efforts on patient engagement
 - Redesigning care
 - Arizona and Minnesota capitated systems reduce high cost institutional care
 - Conscious focus on discrete health issues is required to make change that both improves quality and lowers cost (Geisinger, Jonkoping)
 - Targeting sub-populations – Geisinger works to identify high needs subpopulation and addresses efforts toward their needs.



What we can learn?

- Driving annual initiatives to reduce waste –
 - Geisinger’s bundles drive this focus on reducing waste from failure to follow evidence-based protocols
 - Jonkoping focuses improvement activities on both social and strictly medical issues and on workforce strategies for reducing cost
- Paying providers and allocating resources to support Triple Aim goals – Geisinger physician and provider payment systems support its goals
- Cautious capital budgeting – Jonkoping with its power over the budget for an entire community best-positioned to address over-utilization related to excess medical capacity
- Monitoring performance using evidence-based quality & cost measures – All examples are focused on measurement, although they vary how they use information to drive changes
- Using provider agreements to align incentives – Geisinger seems to have given most attention to this issue.





An **Innovative Program**
 Keeping Older Adults
 Independent in the Community



Unlike other Medicare/Medicaid managed care programs operated in the State of Oregon.... *PACE (Program of all Inclusive Care for the Elderly)* is unique

- **Provider Based Program**
 - **Interdisciplinary team approach**
 - **Assumes full risk until death or discharge – meeting long term needs**
 - **20 years of experience managing medically complex care with capitation**



Unlike other Medicare Advantage programs, PACE serves a subset of the most frail beneficiaries....

- **Creates a “medical home” built on a long term relationship with a PCP who manages chronic and urgent care needs.**
- **Provides access to an integrated Medicare & Medicaid benefit package**
 - **PACE organizations are health care providers, not large insurers**
 - **Fully accountable for cost AND quality**



Who Does PACE serve?

- 55 years and older
- Nursing Facility eligible
- Able to live safely in the community
- Reside in our zip codes



Cully	126 participants
Glendoveer	98 participants
Gresham	330 participants
Irvington Village	60 participants
Lambert House	48 participants
Laurelhurst	194 participants
Marie Smith Center	56 participants

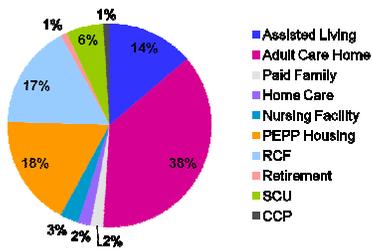
Total 2/1/11	912 participants
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Integration of long term care residential services with coordinated medical care is critical to the success of PACE.

The frailty of our PACE cohort is demonstrated by the fact that 87% require Assisted Living, Adult Care Home, PEPP Housing or Residential Care settings.

Participant Living Situation
February 1, 2011 (N=912)





PACE Center Services



Transportation

In a PACE model, the role of the PCP is critical for prevention & utilization mgmt.



- Currently, our ratio is 1:100 enrollees per PCP –

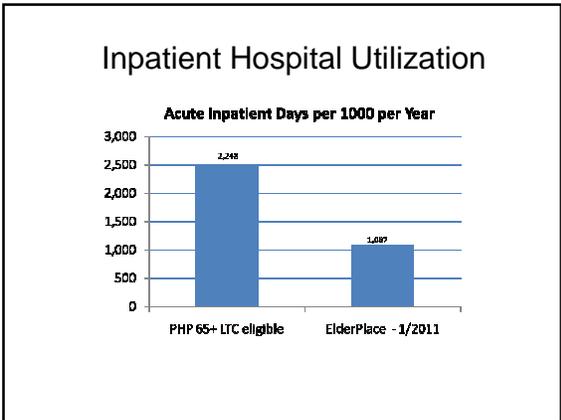
This Drives our Quality

HCC (Diagnostic) Category	PEPP %	All PACE Programs %
Drug & Alcohol Psychoses	6.9	1.64
Congestive Heart Failure	25.1	21.17
Major Depression, Bipolar & Paranoid	31.4	21.23
Renal Failure	32.6	29.07
Vascular Disease	21.6	28.18
Polyneuropathy	15.8	12.35
Hemiplegia/Hemiparesis	12.2	10.74
Source - Population Health Mgmt Review 2010 of PEPP clinical documentation		

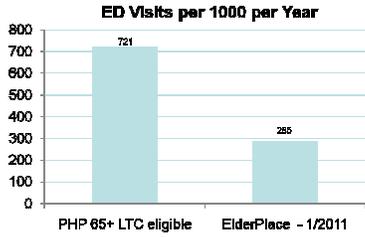


We monitor a comprehensive set of quality metrics for our PACE Population

In January 2011, we had a 7% hospital re-admission rate
Pneumovax immunization rate = 97%
Influenza immunization rate = 95%



Emergency Department Utilization





PEPP provides palliative and end of life care to our enrollees.

143 Deaths Occurred in 2010
126 Deaths Occurred in 2009

- Only 12% of these deaths were in an acute hospital.
- 98% had POLST forms delineating wishes.

Quality Care Leads to Longer Life Expectancy

“PACE clients have a significantly lower risk of dying, compared to similar clients who receive care in other home and community based service (HCBS) modalities. In the first 12 months after enrollment only 13 percent of PACE clients died, compared to 19 percent of HCBS clients. **By year three, 29 percent of PACE enrollees had died, compared to 45 percent of HCBS clients”.**

Source: Mancuso, D., Yamashiro, G., Felver, B. PACE An Evaluation, Washington State Department of Social and Health Services Research & Data Division, Report Number 8.26, June 29, 2005.



When responding to Health Care reform – consider the following hallmarks of a PACE Program

- **Importance of Prevention**
- **Interdisciplinary Team Managing Complex Care across Entire Continuum**
- **Palliative Care**
- **Focus on Quality Outcomes**



An **Innovative Program**
Keeping Older Adults
Independent in the Community

Case Study: James

James, a 68-year-old man, lives alone. He was admitted to the hospital with shortness of breath and diagnosed with pneumonia and underlying heart failure. He is also diabetic with a below the knee amputation and uses a chair. He was provided with instructions about new medications and diet before discharge and asked to see his physician in the office in two weeks. James is unable to handle his own scheduling and is reliant on his sister Martha, who tried to schedule his visit to the physician's office, but had difficulty reaching the scheduler. Finally, she was able to set up a visit for three weeks later.

James didn't mention to Martha that he took the three-day supply of Lasix the hospital sent home with him but never filled his prescription; he felt well again and thought the expense unnecessary. When he noticed swelling in his leg, he didn't want to bother the "busy doctor" and dreaded the ordeal of calling the office again.

After 11 days, James was readmitted to the hospital with increased shortness of breath, marked edema of his lower leg, a weight gain of 25 pounds, and mildly elevated brain natriuretic peptide (BNP), a marker of cardiac insufficiency. His hospital stay went well, but James' stress level was high, his blood pressure was elevated, and another drug was added to his medication regimen.

While James was in the hospital, Martha was also admitted for an emergent surgery. After his discharge, James began eating in fast food restaurants as he worried about his sister's health and juggled visits to Martha's bedside when his neighbors could give him a ride to the hospital. The day Martha came home from the hospital, James was readmitted with exacerbation of heart failure.

Case Study: Sara

Sara is a 24 year old obese female who recently presented to the local emergency department requesting help with a migraine. A quick glance at her records from previous visits showed that this was her second visit this month, her 11th in the past 6 months, and that she was on target to have another year with over 20 visits.

In the acute care setting of the ER, her symptoms are treated with IV narcotics, she is referred back to her primary care provider (PCP), and sent home. She leaves relieved of pain, but continues to feel depressed. She reports feeling labeled a "drug addict" and given the impression that "it is all in my head." Sara has been cycling through the ED at a rate of 20 visits per year, and an annual cost to Medicaid that is 10 times that of the average member.

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Memorandum

To: Members, Health Systems Transformation Team

From: Jeremy Vandehey, OHA Community Engagement Coordinator

Date: February 8, 2011

Subject: Transformation public input through February 7, 2011

Following each Health Systems Transformation Team meeting, questions similar to what were discussed at the Team's meeting are posted on OHA's online survey tool, OHA Feedback (<http://oha.oregon.gov>), for public and stakeholder input. In addition, we are soliciting input by e-mail to ohpb.info@state.or.us and through testimony at the Oregon Health Policy Board's meetings. I have attached summaries of the input received through OHA Feedback and by e-mail since the last Team meeting for your consideration. Please let me know if you have any questions.

Health Systems Transformation Team
Week 1 Input from OHA Feedback
<http://oha.oregon.gov>

Summary: 11 users responded to some or all of the questions this week.

Section 1: “We want to hear from you”

Question 1: What problems do you face receiving care and services?

Please explain problems and barriers that you, friends, or family members have faced because of a lack of integration and coordination of care and services, including:

- physical health
- mental health and addiction services
- oral health
- long-term care, and
- social support services

9 responses:

<p>It's my adult disabled daughter. She and others like her need easier ways to get good dental care. Her tooth problems ARE medical problems and poor dental care causes more medical problems.</p> <p>Her dental problems are, in part, because of epilepsy issues but I, also, have to take some blame. I didn't understand the importance of taking better care of her teeth. I neglected my teeth but they always stayed in good shape. I needed an adviser to clue me in. Doing this for other parents would save a lot of money by preventing future problems.</p>
<p>The health insurance coverages are not defined clearly.</p>
<p>In the type of business I work in, Mental Health Services are desperately needed and those who need them do not qualify. There is always someone who either makes way too much in income that has no insurance and has to pay out of pocket for everything and it becomes a choice of do I pay my bills or do I get the help I need. Then the other side is they have low/no income and are often times turned away with no help because they do not meet the qualifications for receiving care.</p>
<p>We need clearly defined rules and coverages that do not punish those that work and those who need to work but can't due to physical/mental matters.</p>
<p>Ideally there should be quality care , services and support offered at the same level to all regardless of income level.</p>
<p>Finding care providers who take OHP.</p>
<p>Upon treatment from addiction, I'm having trouble bridging from having nothing, to having services through OHP, to obtaining services on my own. I've begun working, so my food stamps</p>

Continued from page 1:

are much reduced and I'm told I probably make too much to qualify for OHP. Because I'm part-time and wasn't hired in time to qualify for my employer's open enrollment, I don't qualify for benefits until January 2012.

OHP provided very good medical care, as well as prescriptions, and emergency dental care. I don't know what I would have done without the dental care--I had a problem, and didn't realize it until very late, I wouldn't have been able to find, and pay for, an independent provider. I'm told I have a serious issue that could become an emergency at any time--just as my OHP is coming to an end.

I am working to become more self-sufficient: classes this spring at PCC, paying rent, taking over food expenses, buying a bus pass. I don't know how to prioritize paying a physician bill, refilling my prescriptions, preparing for a dental emergency, etc. on twenty hours-a-week at \$8.50 an hour.

There's a lot of "I don't know" in my insecurity, and maybe I'm being afraid for no reason at all.

As a patient I am very lucky, but still wish that dental could coordinate with the rest of my medical needs (i.e. blood pressures taken at dental office communicated to medical office), and easier access to mental health counseling.

As a medical provider (PA in Community Health Center) my patients lack dental coverage, hard to get into long term care at times, hard to access social support, housing, etc... even within the same agency cannot seem to get coordinated care between different areas, such as housing and health care.

My biggest issue is cost for the services and a premium that is very expensive. (\$1428.00 for my husband and I)

Having been denied by Providence after COBRA elapsed due to "pre-existing conditions, our only option was OMIP.

I had to change my insurance because I'm getting divorced (I realize I'm lucky to have it). Now I have to change all my health care providers. I wish I could have kept my other insurance, but it costs too much, and my current employer doesn't offer any insurer choices.

When my daughter had mental health issues, we went to her pediatrician and did not get the mental health and community referrals that we needed. The doctor did not have the information or the insight to share.

The time it took to finally get her effective treatment was over 8 months; that included 3 hospitalizations and 3 residential home stays. She had major depression, a treatable disorder that could have been treated in a community based setting but our family did not have the right system supports in place.

While her 6th psychiatrist did make the right diagnosis, I spent hours and hours each week seeking information and support to find what could help my daughter. When I finally met other parents with kids with similar issues, I really started to find the resources that helped my daughter.

Continued from page 2:

(It takes more than a weekly 45 minute appointment with a therapist to make the child well.)

We are so thankful that our daughter is doing well today but are sad we didn't more effective treatment sooner. We will spend several years trying to recover financially. In addition our daughter is behind in school and is struggling to make up lost credits. I simply can't quantify the pain and grief our family experienced.

Today I know there are professionally trained family members whose job is to actually help other families through mental health challenges. These are usually available to families with publicly insured kids.

I volunteer with 2 family organizations to help other families. My dream is that every pediatrician's office will have a trained family member that could help them on their way. So in their time of need, when they need the most support, they can get help sooner to get better outcomes.

Granddaughter has DD, age 7, has had pneumonia 9 times. In an effort to find the cause and thus save the system money in the long run, I advocated for an allergist to see her. The allergist is only allowed one visit with her but he was so thorough that he found she is not allergic but immune deficient and he is not allowed to see her again. Now, I will need to continue to push and appeal to solve the issue. Makes no sense since in the long run it saves OHP money to not have her constantly in the hospital, in ICU, on antibiotics, constant PCP visits.

Granddaughter cannot receive immunizations through PCP, and additional issue, so now we have to change so the above can be accomplished with further testing and reactions to Hib.

Seems cruel to make her try all of the less effective seizure meds for months while her seizures are uncontrolled just to save money.

Speech equipment refused based on 1) that she is 18 and "her family can advocate for her medical needs so she doesn't need it." 2) Denied also because we had not trialed the specific equipment even though what works for her is least costly than what most children use. Is the speech clinic supposed to stock every model available to be able to trial?

When a seizure med becomes generic and the pharmacies have to make changes, my granddaughter was denied Keppra by insurance for several days because the generic had entered the market. Even though her neurologist authorized the generic, it took several days for insurance to get things in order and we had to pay for her meds for about a week. There should be a smoother transition!

Question 2: How could the state coordinate care and services differently to resolve the problems or remove the barriers you included in the previous question?

Response:

Employ good cheap (or free) software and used laptops to share patient files on the web (client/doctor password protected of course).
Clearly define allowances, coverages, same level of personal quality care for all individuals regardless of ability to pay.
Pay higher rates to doctors so they'll stay on the plan.
Extend OHP benefits to returning workers so that, like COBRA benefits, we can choose to bridge the gap in coverage between poverty and self-sufficiency.
Again, since our biggest challenge is cost, Affordability is important to us. I am diabetic but healthy and my husband is a newly dx hypertensive with hemochromatosis and is healthy as well. Perhaps different diagnoses could somehow be "weighed".
Single payer system so that life changes (divorce, job changes, etc.) don't require changes in health care delivery.
1. Include trained family members on your Oregon Health Policy Board. 2. Make the medical home requirements include a trained family support provider (a family member with lived experience who has already successfully gone through the system).
Systems of care show repeatedly that using peers for service is best practices.
Care and services are coordinated from a business prospective and that is understandable but someone needs to shake and wake up these folks who don't consider the real life consequences of saving the dollar. Perhaps looking at the long term best choices and consequences from a human perspective.

Section 2: "2011-13 OHA Budget"

Question 1:

In order to balance the OHA budget, the Governor proposes the following for the Oregon Health Plan:

- Reduce administrative costs, increase electronic records, and other continuous improvements
- Implement more restrictions on the preferred drug list and some co-pays for Oregon Health Plan
- Eliminate approximately 40 services from the Oregon Health Plan
- Reduce rates by between 16 and 19 percent that doctors, hospitals, LTC - nursing facilities, community facilities and others receive for treating Medicaid/OHP clients
- Reduce rates by between 16 and 19 percent that doctors, hospitals, LTC - nursing facilities, community facilities and others receive for treating Medicaid/OHP clients

Are there additional measures you would propose?

10 Responses:

- 8 users responded "yes"
- 2 users responded "no"

Question 2: If you answered yes to the previous question, what other ideas do you have to balance the OHA budget while at the same time preserving access and care?

8 Responses:

<p>Allow private money to be co-mingled with OHP money. For instance, OHPs cutbacks mean teeth get pulled instead of paying for root canals. So since OHP would pay for pain control during a tooth pulling procedure, why not allow a patient add private money for the root canal, instead of the extraction, to do a procedure that, in the long run, is a healthier option?</p>
<p>Reduce any (or all) human transportation costs by using the web - less driving and flying, less fuel consumption...</p>
<p>I support the initiation of co-pays for the insured. It may be a headache, but there must be some way to share the responsibility for each service event.</p> <p>Also, care should be initiated by the enrollee: my pharmacy automatically fills my on-going prescriptions and telephones me to tell me they are ready for pick-up. Even though it's been thirty days since my last refill, I often have a few pills left before I will actually run out. I'm two to three months ahead on meds that I frequently forget to take.</p>
<p>Probably already included, but limited expensive tests such as MRI's, may need prior authorization, but need good system in place to approve necessary ones quickly.</p>
<p>research Medical Device costs, placing caps on items such as implants. This would or should assure reduced costs from Hospitals to Patients.</p>
<p>Raise taxes.</p>
<p>I would introduce a sliding scale when giving benefits to people. Some people may actually want ot pay more but have no way of doing so.</p> <p>You are probably laughing, but I know of at least 2 instances in which people needed help but could have paid something. They wanted to pay a portion but a straight forward option did not exist.</p>
<p>See answers to questions 1 and 2 above, these suggestions could help balance the OHA budget while not only preserving but improving access and care.</p>
<p>Mike Saslow, Consumer Advisory Panel, HITOC</p>

Question 3: Please explain what needs to happen in order for your ideas to be successful.

8 Responses:

<p>For all the ideas, educate the public on how to be more responsible with their OHP benefits. Responsible patients can save a lot of money.</p> <p>For instance, dentists complain that they don't like OHP, in part, because they often get no respect from patients who make appointments and don't show up. Or eating something before going to an appointment where they were going to be put under. The dentist or doctor who set up everything now has to scrap it all. So there are professionals who feel alienated and won't work with OHP anymore.</p>
<p>It's not hard. Just make it policy. Make it a priority, Promote those that do it best. Track performance...</p>
<p>Communication. I'm far from stupid and have worked in healthcare myself: many times when I communicated with OHP or CareOregon, the explanations I received sounded as though the "formal" explanation was only partly thought out.</p> <p>I'd enjoy working on a panel to help OHP improve quality and service delivery.</p>
<p>streamlined way to do Prior Authorizations for expensive tests AND expensive drugs.</p>
<p>Continue to work on these issues, I know they are hard.</p>
<p>Feedback is so appreciated, I thank you, Kate McFadden</p>
<p>Create an accurate media campaign that scares people into thinking they too might lose their insurance, health, and everything (bankruptcy) if more money isn't made available to provide health insurance to the population.</p>
<p>When signing people up for the benefit, ask the people if they want the option.</p> <p>Then train the people who assist those applying to explain the process.</p> <p>Then add an additional step at the point of service to ask if the person wants to use the full benefit.</p> <p>Perhaps the implementation would be too difficult....</p> <p>Maybe just have a "would you like to help other Oregonians by making a \$3 or \$5 donation?"</p>
<p>Administrative rule changes with respect to hospital readmissions and ER admissions; and technical advice for adoption of low cost open source interoperable EMRs in nursing facilities.</p>
<p>Mike Saslow, Consumer Advisory Panel, HITOC</p>

Voluntary demographic responses of users:

Where do you live?	What is your occupation?	Are you insured?
Damascus	Service provider	Yes but this about mainly about my daughter who is on OHP.
Medford	HR Manager	Yes
Harbor	Retired	No
Portland, OR	Retail Clerk	OHP, for two more months.
Portland	Physician Assistant (PA)	Yes
warrenton OR 97146	retired Surgical RN, husband retired OR state trooper	yes
Portland	RN	yes
97060	test center assistant	privately
Outside of Corvallis, Benton County, OR	retired manager of R&D. state senior services	yes
Portland, Oregon	Social worker/manager	yes

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Public Input for the Oregon Health Policy Board and
Health System Transformation Team
January 24, 2011 to February 4, 2011

Doc #	Summary	Comment Type	Writer
1	Integrative medicine is an effective way to reduce medical costs. Numerous studies across the country have demonstrated the promise of this method. One important aspect of integrative medicine is lifestyle intervention.	Email Submitted: 1/24/2011	Marnie Loomis
2	Patients, not members of the public at large, need to bear the costs of self-inflicted damage to their health in any system you devise	Email Submitted: 1/28/2011	Milt Jones
3	Please look at and consider the situations of all Oregonians when making policy decisions for a positive future.	Email Submitted: 1/28/2011	Jake and Ozlem Jenkins
4	In favor of a single payer health system. Contact Dr. Margaret Flowers for more information.	Email Submitted: 1/28/2011	No name given.
5	The solution is to have well funded free or sliding scale community health clinics, staffed with nurse practitioners, physician assistants, social workers, and able to provide home health visits.	Email Submitted: 1/30/2011	Deborah Samuels
6	Raised questions about how integrated health and service organizations will interplay with the work of the Transformation Team.	Email Submitted: 1/31/2011	Nina Salzman
7	In relation to mental health, if 40% of people are taken off OHP, they will not be able to get the crucial preventive or palliative care that they need.	Email Submitted: 1/31/2011	Barbara Alexander
8	Teach families on Medicaid how to treat common ailments so that they do not have to see a doctor for a cold. Make emergency room visits require a prior authorization.	Email Submitted: 2/1/2011	Michelle DeVoe
9	The switch to generic medicines has been necessary but not sufficient. When generics are unavailable, the state should tier the available drugs through a competitive bidding process.	Email Submitted: 2/1/2011	Dave Gilmour
10	Easter Seals Oregon encourages the Board to consider the power and effectiveness of volunteers (with an emphasis on senior volunteers) and non-profits in sustaining healthy communities.	Email Submitted: 2/2/2011	Carol Cookson
11	There needs to be reform in the regulations on health insurance companies' determinations of eligibility. This would help alleviate some of the financial burden on the state to cover the uninsured.	Email Submitted: 2/2/2011	BJ Merriman

12	Availability of health care does not equal affordability. For people who just barely do not qualify for any number of programs, the financial burden is great.	Email Submitted: 2/2/2011	Joseph Lipkind
13	Community mental health services must be strengthened.	Email Submitted: 2/3/2011	Jim Russell
14	If high risk births outside of the hospital increase overall costs to Medicaid spending, then eliminating them would be prudent.	Email Submitted: 2/3/2011	Sharron Fuchs
15	We could save a lot of work time in Salem by having field workers' and medical experts' jobs better suited to their skills.	Email Submitted: 2/4/2011	Susan Trachsel
16	It is important to have a representative from a fire department/ambulance service on the Health Systems Transformation Team.	Email Submitted: 2/4/2011	Randy Jackson
17	Oregon Medicaid should no longer reimburse licensed direct entry midwives for high-risk home births.	Email Submitted: 2/4/2011	Lani Doser

Health Affairs

At the Intersection of Health, Health Care and Policy

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The Triple Aim: Care, Health, And Cost

The remaining barriers to integrated care are not technical; they are political.

by **Donald M. Berwick, Thomas W. Nolan, and John Whittington**

ABSTRACT: Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration. [*Health Affairs* 27, no. 3 (2008): 759–769; 10.1377/hlthaff.27.3.759]

CONGESTIVE HEART FAILURE (CHF) is the most common reason for admission of Medicare patients to a hospital.¹ Sadly, 40 percent of Medicare patients discharged after admission for CHF are readmitted within ninety days, even though well-designed demonstration projects have shown for years that that rate can be reduced by more than 80 percent with proper management of patients.² Patients experience this reactive system as one providing poor service and lacking memory. Caregivers experience frustration, despite their best efforts.

■ **U.S. health system scorecard.** CHF care is not an isolated case. It is a prime example of what goes wrong when a health care system lacks the capacity to integrate its work over time and across sites of care. The recent “Scorecard” from the Commonwealth Fund Commission on a High Performance Health System gives the U.S. health care system an overall score of 66 percent, with 100 percent referring to the top decile of known performance.³ The commission notes that even though U.S. health care expenditures are far higher than those of other developed countries, our results are no better. Despite spending on health care being nearly double that of the next most costly nation, the United States ranks thirty-first among nations on life expectancy, thirty-sixth on infant mortality, twenty-eighth on male healthy life expectancy, and twenty-ninth on female healthy life expectancy.⁴ As a side effect of the

.....
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cost burden, the United States is the only industrialized nation that does not guarantee universal health insurance to its citizens. We claim we cannot afford it.

■ **Care improvement efforts.** Most recent efforts to improve the quality of health care have aimed to reduce defects in the care of patients at a single site of care in all six dimensions identified by the Institute of Medicine (IOM): safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.⁵ Slow progress in each of these is occurring, as measurements, incentives, knowledge, will, and experiments come increasingly into alignment. However, the task of improving individuals' care is hardly completed. In the wave of projects on "pay-for-performance" (P4P) and public reporting, policymakers, payers, and health care leaders are still struggling to make highly reliable and safe health care a norm rather than an exception.⁶ Moreover, too few improvement efforts address defects in care across the continuum, such as those that plague patients with CHF.

Defining The "Triple Aim"

Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.

■ **Interdependent goals.** The components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two, sometimes negatively and sometimes positively. For example, improving care for individuals can raise costs if the improvements are associated with new, effective, but costly technologies or drugs. Conversely, eliminating overuse or misuse of therapies or diagnostic tests can lead to both reduced costs and improved outcomes. The situation is made more complex by time delays among the effects of changes. Good preventive care may take years to yield returns in cost or population health.

■ **An exercise in balance.** Pursuit of the Triple Aim is an exercise in balance and will be subject to specified policy constraints, such as decisions about how much to spend on health care or what coverage to provide and to whom. The most important of all such constraints, we believe, should be the promise of equity; the gain in health in one subpopulation ought not to be achieved at the expense of another subpopulation. But that decision lies in the realms of ethics and policy; it is not technically inherent in the Triple Aim.

A health system capable of continual improvement on all three aims, under whatever constraints policy creates, looks quite different from one designed for the first aim only. The balanced pursuit of the Triple Aim is not congruent with the current business models of any but a tiny number of U.S. health care organizations. For most, only one, or possibly two, of the dimensions is strategic, but not all three. Thus, we face a paradox with respect to pursuit of the Triple Aim. From

“The Holy Grail of universal coverage may remain out of reach unless we can reduce per capita costs.”

.....

the viewpoint of the United States as a whole, it is essential; yet from the viewpoint of individual actors responding to current market forces, pursuing the three aims at once is not in their immediate self-interest.

Take hospitals as an example. Under current market dynamics and payment incentives, it is entirely rational for hospitals to try to fill beds and to expand services even though the work of Elliott Fisher and John Wennberg strongly predicts the net effect to be much higher cost and no higher quality.⁷ Most hospitals seem to believe that they can protect profits best by protecting and increasing revenues. Higher efficiency in local production can help, too, but systemic efficiencies that reduce revenues or admission rates are threats to profit. The same payment dynamics often lead hospitals to focus only on care within their walls, viewing CHF readmissions, for example, as indicating defects outside the hospital, not as their responsibility to avert.

■ **A “tragedy of the commons.”** Rational common interests and rational individual interests are in conflict. Our failure as a nation to pursue the Triple Aim meets the criteria for what Garrett Harden called a “tragedy of the commons.”⁸ As in all tragedies of the commons, the great task in policy is not to claim that stakeholders are acting irrationally, but rather to change what is rational for them to do. The stakes are high. Indeed, the Holy Grail of universal coverage in the United States may remain out of reach unless, through rational collective action overriding some individual self-interest, we can reduce per capita costs.

■ **Obstacles to pursuit of the Triple Aim.** The changes we would need to mobilize pursuit of the Triple Aim are large, and the obstacles are daunting. Among the biggest barriers are supply-driven demand; new technologies including many with limited impact on outcomes; physician-centric care; little or no foreign competition to spur domestic change, as it does in manufacturing; and too little appreciation of system knowledge among clinicians and organizations, leading them to suboptimize the components of the system with which they are most familiar, at the expense of the whole.

■ **Promising innovations.** Despite these obstacles, a handful of innovators are starting to challenge the U.S. health care market. These disruptive innovations are by no means yet mainstream, but the examples align surprisingly well with the objectives of the Triple Aim. For example, innovations in primary care such as the medical home, as well as “Minute Clinics” and other retail health care providers are challenging the prevailing approach to primary care.⁹ Experiments in telecommunications are offering care that is no longer location-specific.¹⁰ One form of foreign competition—“medical tourism”—is beginning to catch on. Also, a few hospitals, such as Virginia Mason Medical Center, Denver Health, and ThedaCare, are learning

to use systems knowledge to reduce costs and improve profit, such as by adapting “lean production” to health care.¹¹

■ **Measuring health care quality.** In general, opacity of performance is not a major obstacle to the Triple Aim. Many tools are in hand to construct part of a balanced portfolio of measures to track the experience of a population on all three components. At the Institute for Healthcare Improvement (IHI), for example, we have developed and are using a balanced set of systemwide measures closely related to the Triple Aim.¹² A more complete set of system metrics would include ways to track the experience of care in ambulatory settings, including patient engagement, continuity, and clinical preventive practices.

■ **Measuring costs and health status.** Measuring per capita costs is still a big challenge; it requires that we capture all relevant expenditures, index them appropriately to local market circumstances, and be able to measure actual costs in a care system whose current methods of pricing and discounting obscure them. Population health measures would require some form of registration or sampling for defined populations and would be speeded by widespread implementation of electronic health record systems. Citing one serious gap, the IOM recently concluded that measures of both cost and care across the continuum, impeded by the fragmentation of delivery itself, still need much more developmental work.

Preconditions For Pursuit Of The Triple Aim

Despite the social need and the feasibility of measurement, actual pursuit of the Triple Aim remains the exception. What would be the preconditions for changing that?

We suggest that three inescapable design constraints underlie effective accomplishment of the Triple Aim: (1) recognition of a population as the unit of concern, (2) externally supplied policy constraints (such as a total budget limit or the requirement that all subgroups be treated equitably), and (3) existence of an “integrator” able to focus and coordinate services to help the population on all three dimensions at once.

■ **Specifying a population of concern.** A “population” need not be geographic. What best defines a *population*, as we use the term, is probably the concept of enrollment. (This is different from the prevailing meaning of the word *enrollment* in U.S. health care today, which denotes a financial transaction, not a commitment to a healing relationship.) A registry that tracks a defined group of people over time would create a “population” for the purposes of the Triple Aim. Other examples of populations are “all of the diabetics in Massachusetts,” “people in Maryland below 300 percent of poverty,” “members of Group Health Cooperative of Puget Sound,” “the citizens of a county,” or even “all of the people who say that Dr. Jones is their doctor.” Only when the population is specified does it become, in principle, possible to know about its experiences of care, its health status, and the per capita costs of caring for it. Under current conditions, such registries are rare in the United States,

especially for geographically defined populations. Creating them will require research, development, and investment.

■ **Policy constraints.** The policy constraints that shape the balance sought among the three aims are not automatic or inherent in the idea. Rather, they derive from the processes of decision making, politics, and social contracting relevant to the population involved. For example, a nation or state might or might not decide that “universal coverage” is mandatory; a community in a town meeting or an employer in negotiation with a labor union might or might not decide to spend no more than x dollars per capita or y dollars per year on health care. Logically—that is, mathematically—optimizing on three aims at once requires constraints on at least two of them.

■ **Integrator.** An “integrator” is an entity that accepts responsibility for all three components of the Triple Aim for a specified population. Importantly, by definition, an integrator cannot exclude members or subgroups of the population for which it is responsible. The simplest such form, such as Kaiser Permanente, has fully integrated financing and either full ownership of or exclusive relationships with delivery structures, and it is able to use those structures to good advantage. We believe, however, that other models can also take on a strong integrator role, even without unified financing or a single delivery system. That role might be within the reach of a powerful, visionary insurer; a large primary care group in partnership with payers; or even a hospital, with some affiliated physician group, that seeks to be especially attractive to payers.

In crafting care, an effective integrator, in one way or another, will link health care organizations (as well as public health and social service organizations) whose missions overlap across the spectrum of delivery. It will be able to recognize and respond to patients’ individual care needs and preferences, to the health needs and opportunities of the population (whether or not people seek care), and to the total costs of care. The important function of linking organizations across the continuum requires that the integrator be a single organization (not just a market dynamic) that can induce coordinative behavior among health service suppliers to work as a system for the defined population.

Functions Of An Integrator

■ **Involving individuals and families.** Pursuit of the Triple Aim requires that the population served become continually better informed about both the determinants of their own health status and the benefits and limitations of individual health care practices and procedures. An effective integrator would work persistently to change the “more-is-better” culture through transparency, systematic education, communication, and shared decision making with patients and communities, rather than by restricting access, shifting costs, or erecting administrative hurdles to care. Many members of the population, especially those with chronic illnesses, will need someone who can work with them to establish a plan for their ongoing care, guide them

through the technological jungle of acute care, advocate for them, and interpret.

■ **Redesign of primary care services and structures.** We believe that any effective integrator will strengthen primary care for the population. To accomplish this, physicians might not be the sole, or even the principal, providers. Recently, physicians and other clinicians have proposed principles for expanding the role of primary care under the title of the medical home. This expanded role includes establishing long-term relations between patients and their primary care team; developing shared plans of care; coordinating care, including subspecialists and hospitals; and providing innovative access to services through improved scheduling, connection to community resources, and new means of communication among individuals, families, and the primary care team facilitated by a patient-controlled personalized health record. The integrator would assume responsibility for building the capability and infrastructure to enable primary care practices to function in this expanded role.

■ **Population health management.** The integrator would be responsible for deploying resources to the population, or for specifying to others how resources should be deployed. Segmentation of the population, perhaps according to health status, level of support from family or others, and socioeconomic status, will facilitate efficient and equitable resource allocation.¹³ The growing availability of high-quality health information on the Internet will help all segments manage their own care and understand options for treatment.

Today's individual health care processes are designed to respond to the acute needs of individual patients, rather than to anticipate and shape patterns of care for important subgroups. An integrator would act differently, assigning much more value and many more resources, for example, to the monitoring and interception of early signs of deterioration among the 100 CHF patients in a doctor's panel or the 1,000 CHF patients who used the hospital last year.

Famously, the "actual" causes of mortality in the United States lie in behavior that the individual health care system addresses unreliably or not at all, such as smoking, violence, physical inactivity, poor nutrition, and unsafe choices.¹⁴ An integrator would increase preventive efforts. An integrator would also encourage and cooperate with governmental policies, agencies, and programs to discourage smoking, combat obesity, provide alternatives to violence and substance abuse, and address community determinants of mental health problems.

■ **Financial management system.** The broken financing system of the present mirrors the fragmented care system. An effective integrator would assure that payment and resource allocation support the Triple Aim. An important first step for a systems approach to cost control would be defining, measuring, and making transparent the per capita cost of care for a defined population. For example, companies could begin to show on employees' paychecks the amount of money spent per employee by the company to provide health insurance. The Centers for Medicare and Medicaid Services (CMS) could provide regions with cost information per benefi-

ciary to allow comparisons of costs and inflation across the country.

A mainstay of reduction and control of per capita costs would be yearly initiatives to reduce waste in all of its forms, especially procedures, tests, and visits that represent rework, errors, unscientific care, or otherwise valueless services. George Isham, medical director of HealthPartners in Minneapolis, has called for a project to identify the ten most common forms of waste in each medical specialty.¹⁵ Any integrator collaborating on improvement of value with its suppliers of specialty care would be very interested in Isham's list. An indication of progress on the Triple Aim would be doctors' leading and energetically participating in such efforts.

Perhaps the most powerful needed change is to disrupt the dynamics of supply-driven care and instead to match supply better to underlying needs. An integrator would approach new technologies and capital investments with skepticism and require that a strong burden of proof of value lie with the proponent. Operating budgets would encourage thinking across boundaries. An integrator would ask, "Might two additional home outreach nurses be better for the Triple Aim than another cardiologist?" Capital budgets would be informed by the insights of Fisher and Wennberg, and good integrators would encourage through incentives—and, if needed, regulations—strict limits on the growth of facilities.

The hallmarks of proper financial management in a system pursuing the Triple Aim, we suspect, are government policies, purchasing contracts, or market mechanisms that lead to a cap on total spending, with strictly limited year-on-year growth targets.

■ **System integration at the macro level.** A conscientious integrator would aspire to produce or contract for individual care and population-based interventions that are evidence-based and highly reliable. To achieve that, all in the system of care would need access to up-to-date medical knowledge, standardized definitions of *quality* and *cost*, and evidence and measurement collected and distributed by a thoroughly trustworthy body. In effect, patients, caregivers, organizations, and managers would know the "state of the system" with respect to its reliability, adherence to evidence, cost, and progress in improvement.

In most cases, the integrator would not be a direct provider of all necessary services. Instead, it would need to commission some services from suppliers through business relationships consciously designed to facilitate pursuit of the Triple Aim. Michael Porter and Elizabeth Teisberg have called for a redefinition of competition in health care.¹⁶ They assert that value is added by care that produces the best outcomes at the lowest cost over time. An integrator, following their logic, might contract with a multifunctional group of providers to serve a specific subpopulation.

Precedents And Possibilities

The Triple Aim is far from a totally new idea. As one would expect, organizations and other stakeholders in a variety of countries that begin with a population

in mind tend to want to achieve all three goals at once. Among these stakeholders are (1) government-sponsored or -owned health care systems that have legally chartered duties to defined populations and that own facilities, employ clinicians, and provide and manage clinical services (in the United States, these include the Veterans Health Administration, the Indian Health Service, and the Military Health Command); (2) classical staff- and group-model health maintenance organizations (HMOs), such as Kaiser Permanente, HealthPartners, and Group Health Cooperative of Puget Sound, which combine insurance and care delivery functions (although usually not public health systems) for enrolled populations; and (3) national and other governmental health care systems that aggregate tax revenues into global budgets and, through employment, ownership, and contracting, ensure care for populations. Examples include the National Health Service (NHS) in the United Kingdom and health care in Sweden, where counties act as integrators, using general tax revenues to fund the comprehensive care systems that county-level executives organize and improve for their entire population.¹⁷

In the United States, a few additional cases of Triple Aim-oriented organizations have emerged. Some employers, fed up with out-of-control costs but unwilling to give up trying to ensure proper care for their employees, have started their own care systems, reminiscent of the roots of Kaiser Permanente. For example, QuadGraphics, a large U.S. publishing company, started QuadMed, a wholly owned subsidiary that provides care to QuadGraphics employees using a highly innovative model of strong primary care as the mainstay.¹⁸

Occasional entrepreneurial hospital-based systems, often with very high market share and strong community roots, such as Intermountain Health Care, Geisinger Health System, Bellin Health System, and (for care of the underserved) Denver Health, try to knit together components of the care system in virtual aggregates through technical support and innovative contracts. The numerous recent state-level initiatives for universal health insurance coverage inevitably face the Triple Aim as the only route to affordability; Massachusetts, as one example, has established a Quality and Cost Council to try to determine how to keep all three aims in a single field of vision.¹⁹

■ **HMOs as integrators.** So what happened to HMOs? As conceived by their greatest champion, Paul Ellwood, HMOs were, or were intended to be, integrators exactly as we propose, in pursuit of the Triple Aim.²⁰ On closer inspection, the HMO movement was eventually defined by its organizational structure rather than its aims and performance. The experience of people enrolled in HMOs was not sufficiently improved to overcome the restriction of choice of providers or the perceived barriers to access to specialists that became part of the HMO model. Because they restricted care, HMOs were vulnerable to competitive retaliation by indemnity insurers and others, which began offering products called “HMO” or “managed care” that merely managed money, not care. Furthermore, proponents of HMOs might have overestimated the cost-saving potential of proper preventive care, instead of

“Innovations in payment design encourage integrated behavior without the managerial superstructure of an HMO.”

viewing population health status and per capita cost control as separate aims.²¹ Finally, HMOs were competing for doctors and acute care suppliers in an environment in which these providers were in control of demand and thus revenue. The HMO was not an attractive business alternative for them.

■ **Encouraging signs for integrated care.** Even with the similarity between an HMO and our view of the integrator, we are encouraged in large measure because the possibilities of integrated care have so thoroughly changed with the advent of electronic support systems and the possibilities for virtual integration and instant communication that were unimaginable when HMOs were first described. Fisher’s recent proposals for virtual integration of care through extended medical staffs, for example, represent innovations that draw on some of the principles of classical HMOs, but with entirely new processes and relationships at their core.²² Innovations in payment design, such as bundled payment experiments by the CMS for chronic disease management and Harold Luft’s conceptualization of case rates for local microsystems, offer interesting approaches to encouraging integrated behavior without the managerial superstructure of an HMO.²³

■ **What it takes to progress toward integrated care.** From the (we hope temporary) failure of the best features of the HMO concept we take the lesson not that all integrated care is destined to fail, but rather that pursuit of the Triple Aim threatens the U.S. status quo health care system. The current behavior, destructive of the Triple Aim and inimical to the best aspects of sound, managed care, is a predictable, indeed inevitable, consequence of the current rules. If we want different behavior, we will need new financing and competitive dynamics. What new financing or dynamics, different from today’s, would lead rational hospitals to try to reduce readmissions dramatically for CHF?

If we could ever find the political nerve, we strongly suspect that financing and competitive dynamics such as the following, purveyed by governments and payers, would accelerate interest in the Triple Aim and progress toward it: (1) global budget caps on total health care spending for designated populations, (2) measurement of and fixed accountability for the health status and health needs of designated populations, (3) improved standardized measures of care and per capita costs across sites and through time that are transparent, (4) changes in payment such that the financial gains from reduction of per capita costs are shared among those who pay for care and those who can and should invest in further improvements, and (5) changes in professional education accreditation to ensure that clinicians are capable of changing and improving their processes of care. With some risk, we note that the simplest way to establish many of these environmental conditions is a single-payer system, hiring integrators with prospective, global bud-

gets to take care of the health needs of a defined population, without permission to exclude any member of the population.

Indicators Of Progress

In our lighter moments, we have tried to imagine the most elegant possible “Triple Aim Test,” asking, “How would we know at first glance that the care for a population is actually making progress on the Triple Aim?” Our proposed test has only three items. First, hospitals involved in the Triple Aim would be trying to be emptier, not fuller. They would celebrate as success that the hospital is less and less often needed by the population. Second, Fisher and Wennberg would be happier. They would observe that the dynamics of supply-driven care are no longer strong and that patients pull resources, rather than vice versa. And third, patients would say of those who try to maintain and restore their health: “They remember me.” They would recognize that the health care system is mindful of their needs, wants, and opportunities for health even when they themselves forget. Health care would also be mindful that people have excellent uses for their wealth other than paying for care they do not need or for illnesses they could have avoided.

WHETHER OR NOT THE TRIPLE AIM is within reach for the United States has become less and less a question of technical barriers. From experiments in the United States and from examples of other countries, it is now possible to describe feasible, evidence-based care system designs that achieve gains on all three aims at once: care, health, and cost. The remaining barriers are not technical; they are political. The superiority of the possible end state is no longer scientifically debatable. The pain of the transition state—the disruption of institutions, forms, habits, beliefs, and income streams in the status quo—is what denies us, so far, the enormous gains on components of the Triple Aim that integrated care could offer.

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