

Demonstrating Value Using Triple Aim Measurement: Six Things Community Health Centers Can Do

As the health care reimbursement landscape shifts from volume- to value-based care, community health center leaders are embracing the Triple Aim. First defined by the Institute for Healthcare Improvement, the Triple Aim describes three goals: improve the individual experience of care, improve the health of populations, and reduce the per capita costs of care for populations.^{1,2} Measuring and analyzing the Triple Aim can help community health centers demonstrate value—that is, keep patients healthy and give patients high-quality care they are satisfied with without increasing cost.³

But measuring the Triple Aim can be hard—a comprehensive measurement system doesn't exist; and appropriate measures can be difficult to define. Necessary data often reside across multiple organizations and systems; thus, identifying and obtaining those data can be challenging. Also, analyzing and visualizing the data for all three aims simultaneously might not be easy.

Blue Shield of California Foundation has worked with American Institutes for Research to help community health centers in California develop and pursue a Triple Aim measurement strategy. Given the move toward value-based purchasing, there is no better time than now.

Here are six things community health centers can do to start.

1. **Make it a priority to measure the Triple Aim.** Measuring the Triple Aim will help community health center leaders demonstrate value and prepare for value-based payment. The payment environment is changing *now*. By 2018, 90% of Medicare payments will be tied to value.⁴ Likewise, states are shifting to alternative health care delivery systems that hold payers and providers accountable for the quality and cost of patient care.^{5,6}

Also, implications of measuring the Triple Aim can be profound. By simultaneously examining health outcomes, patient experience, and cost for a specific subpopulation or topic, community health center leaders can identify strategies for improvement in health and quality without driving up costs. They also can ensure health and quality don't diminish when costs are lowered, thus ensuring value-based care for their patients.

2. **Decide on a topic or population to measure and analyze.** Community health centers can choose a defined population to simplify measurement and data interpretation. An example of a defined population is patients with hypertension who are part of a blood pressure control program.

To choose a population, it helps to take a look at data community health centers already collect and report. First, quality improvement (QI) teams might look at what they report out to the Health Resources and Services Administration's Uniform Data System (UDS) or for the Centers for Medicare & Medicaid Services' meaningful use (MU) requirements. Or, they might think about payer priorities, such as the six priority areas for Value Based Pay for Performance in California from the Integrated Healthcare Association.⁷ Finally, QI teams might consider prevalent and preventable conditions in their area by looking at community health needs assessments.

3. **Pick a small set of related health, experience, and cost measures to start.** Just as a QI team might pick a population or topic based on existing data, they can also pick measures the same way. For health measures, teams might look to UDS and MU measures or measures they report to pay-for-performance programs.

For patient experience, QI teams can administer a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey,⁸ put together their own surveys, or use proxy measures that are associated with patient

Resources

Visit <http://www.measuretripleaim.org> for detailed information on developing a strategy, explanatory videos, downloadable resources, and more. E-mail TripleAimMeasurement@air.org.

experience. An example of a patient experience proxy measure is time from check-in to face-to-face time with the health care provider.

Community health center staff should always be sure to include a cost measure in the measure set, however difficult it may seem. If the community health center doesn't receive claims data from payers, community health centers can consider cost proxies that measure resource utilization. Examples include 30-day readmissions or nonemergent use of the emergency department.

If it is necessary to identify new measures, QI staff can look at measure inventories, such as CMS's Measures Inventory,⁹ the Agency for Healthcare Research and Quality's Quality Indicators,¹⁰ or the Healthcare Effectiveness Data and Information Set (HEDIS).¹¹

When finalizing the measurement strategy, QI staff will want to make sure that the measures are related by topic or population and conceptually linked to one another. In other words, improvements in health might be associated with changes in cost and experience.

- 4. Fill gaps in data.** Gaps in data are common and usually occur in the areas of patient experience and cost. To fill gaps in patient experience, community health centers can administer surveys, interview patients, or try innovative methods such as pulse (1-min) surveys.

To fill cost data gaps, community health center staff can start to work with their health plans to get claims data. Leaders (e.g., chief financial officers, chief operating officers, controllers) in both the community health center and the plan should champion data exchange. As payers, health plans are also interested in improving outcomes, so finding these champions can facilitate relationships.

- 5. Use data to visualize the Triple Aim.** QI teams and data analysts can study health, patient experience, and cost data together across clinic sites, providers, and regions. Visualizing the Triple Aim provides powerful images and tools to analyze and demonstrate value beyond traditional paper reports. It is possible to visualize the Triple Aim using basic software, such as Excel, or more advanced data visualization software. By using images to represent the data, community health centers can see the Triple Aim across clinic sites, group clinic sites and providers according to value, and assess the Triple Aim across community health centers within the region.
- 6. Communicate about the Triple Aim and value to stakeholders.** Community health center leaders should tailor messages about data to key stakeholders, including their own providers and care teams and payers. These conversations can help to improve data quality and drive improvement.

It is important to remember that the steps outlined in this issue brief are iterative and will take time. As imperfect as a community health center's data may be or as daunting as the task of pursuing a Triple Aim strategy may seem, community health center leaders might remember that the only place to start is where they are now, with what they have, in order to achieve and demonstrate value-based care for their patients, providers, and payers.

¹ Institute for Healthcare Improvement. (2016). The IHI Triple Aim. Retrieved from <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx>

² Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs (Millwood)*, 27(3), 759–769.

³ Wang, G., Boutwell, A., Kary, W., & Downing, L. (2015, June 18). IOM's *Vital Signs* report lays out steep but doable climb for safety-net organizations [Blog post]. Retrieved from <http://healthaffairs.org/blog/2015/06/18/ioms-vital-signs-report-lays-out-steep-but-doable-climb-for-safety-net-organizations/>

⁴ Burwell, S. M. (2015). Setting value-based payment goals—HHS efforts to improve U.S. health care. *New England Journal of Medicine*, 372(10), 897–899.

⁵ Takach, M. (2012). About half of the states are implementing patient-centered medical homes for their Medicaid populations. *Health Affairs (Millwood)*, 31(11), 2432–2440.

⁶ The Henry J. Kaiser Family Foundation. (2015, June 22). Medicaid delivery system and payment reform: A guide to key terms and concepts. Retrieved from <http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/>

⁷ Integrated Healthcare Association. (2016). California's Value Based Pay for Performance Program. Retrieved from <http://www.ihl.org/our-work/accountability/value-based-p4p>

⁸ <https://cahps.ahrq.gov/>

⁹ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>

¹⁰ <http://www.qualityindicators.ahrq.gov/>

¹¹ <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>