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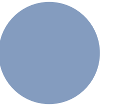
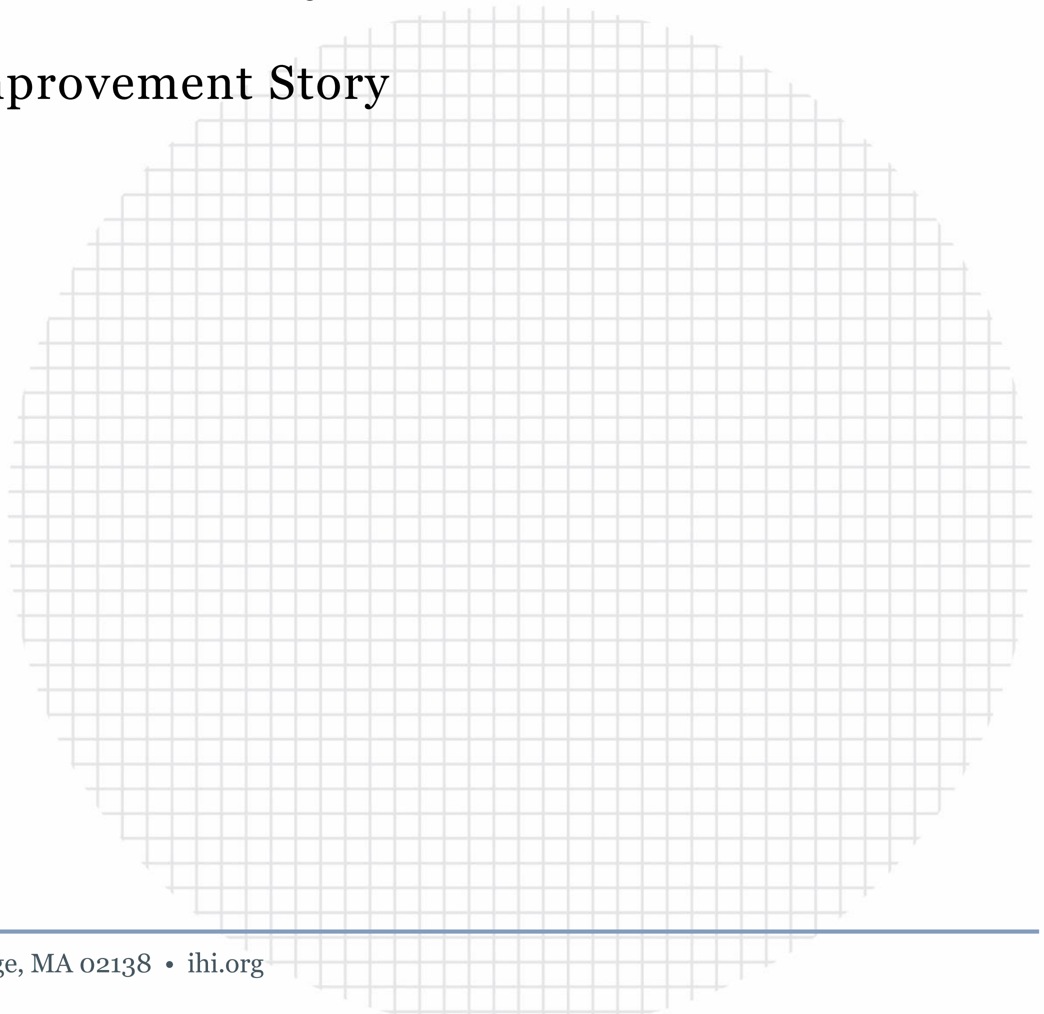


Health Improvement Partnership of Santa Cruz County

A Triple Aim Improvement Story



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The Institute for Healthcare Improvement (IHI) is a leading innovator in health and health care improvement worldwide. For more than 25 years, we have partnered with visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Recognized as an innovator, convener, trustworthy partner, and driver of results, IHI is the first place to turn for expertise, help, and encouragement for anyone, anywhere, who wants to change health and health care profoundly for the better. To advance our mission, IHI's work is focused in five key areas: Improvement Capability; Person- and Family-Centered Care; Patient Safety; Quality, Cost, and Value; and Triple Aim for Populations. Learn more at ihi.org.

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Introduction

In the past decade, much attention has focused on forming coalitions to meet shared community improvement goals. The Institute for Healthcare Improvement (IHI) has been instrumental in facilitating collective efforts to achieve the Triple Aim within communities and regions — that is, improve the experience of care and the health of a population while also reducing the per capita cost of care.

A vanguard of communities is pursuing a regional focus to improve population health through the broad lens of the social determinants of health. These communities are aligning the efforts of diverse stakeholders, spanning health and social care systems, faith communities, and local resident associations.

For those pursuing the Triple Aim for geographic populations, IHI offers specific guidance that emphasizes the following core components:

- Identification of a population for which the community holds itself accountable for the Triple Aim;
- A clear purpose, including what the community or region is trying to accomplish and why;
- An established portfolio of projects and investments to support the pursuit of the Triple Aim based on the needs and assets of the population;
- A means of governing and integrating the community initiatives and investments; and
- The creation of a learning system to track progress over time, including a cogent set of high-level measures that operationally define what a community means by health of a population, experience of care, and per capita cost.

IHI's guidance aligns well with the *Stanford Social Innovation Review* (*SSIR*), which provides thought leadership in *collective impact* and identifies five conditions for shared success in collective impact: a shared vision for change, shared measurement and data collection, mutually reinforcing activities, continuous and open communication, and backbone support. In addition, the *SSIR* highlights the crucial role that backbone organizations play in collective impact initiatives, including the following activities: guiding vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding.

This Triple Aim improvement story examines the work of one such vanguard community pursuing a regional focus to improve population health, and the backbone organization that facilitates the local coalition.

Overview

The Context

The Health Improvement Partnership (HIP) of Santa Cruz County, California, serves as the backbone organization for a coalition of stakeholders: cultivating shared goals, collecting data from stakeholder groups, establishing venues for collaboration, communicating clearly and

transparently, and incubating new care models. This Triple Aim improvement story describes how HIP was formed and functions as the backbone organization for the county's Triple Aim efforts, and how its governance structure defines and supports a portfolio of projects to improve the health of the community's population.

The Coalition

HIP is a "nonprofit coalition of public and private health care leaders dedicated to increasing access to health care and building stronger local health care systems" in Santa Cruz, California. The group has selected key health needs to improve, including diabetes, children's wellness, and advance directives. In addition, HIP identifies contextual challenges for improvement such as uninsured populations, access to primary care, coordination between hospitals and safety net clinics, and Medicare reimbursement rates.

The Population

Santa Cruz County has a population of 265,000 residents, with approximately 60,000 people served by Santa Cruz County health care providers, including some patients who live outside of the county. The county population is 58.6 percent white, 32.9 percent Latino, 4.8 percent Asian, 1.8 percent Native American, and 1.4 percent black. The population is diverse and includes a growing number of both young technology entrepreneurs and undocumented immigrants; 14.6 percent of the county's population live below the federal poverty level and 52 percent of patients have no insurance coverage, indicating health care access challenges that are likely due to lack of citizenship documentation. Seventy-five percent of patients served by HIP's safety net clinics live below the federal poverty level, and 68 percent of these patients are Latino.

The Aim

HIP aims to unite public and private health care providers and key community stakeholders to advance high-quality, high-value, patient-centered care to improve the health of all members of the Santa Cruz County community.

The Triple Aim Story

The Health Improvement Partnership (HIP) of Santa Cruz County was a participating partner in IHI's Triple Aim Improvement Community from 2009 to 2014. In January 2015, Catherine Craig, IHI Triple Aim faculty, spoke with Eleanor Littman, Executive Director, Jordan Turetsky, former Health Navigator Program Coordinator, and Shelly Wingert, Safety Net Program Coordinator, about their Triple Aim journey thus far. The following is an edited version of that conversation.

How did HIP form as a backbone organization that convenes diverse stakeholders, aligning and supporting their work in the community?

Launched in 2004, HIP grew out of local collaboration among health organizations. The collaborative efforts began in 2002, when the Santa Cruz County Health Department won a federal Healthy Communities Access Program (HCAP) grant. The county took the lead and focused on improving health care access for three populations — low-income childless adults, undocumented

people, and young entrepreneurs — all of whom had little or no access to health care. As prominent health care leaders from competing organizations partnered together with the county to improve access through the federal grant, they saw the value of collaboration over competition.

In 2002, the county contracted with a well-known former nurse executive to pull together a wider group of leaders and practitioners. By 2004, various partners were working together on a community diabetes registry, and we all realized that to keep the collaboration going strong, we should incorporate.

With no large managed care organization or county hospital in the community, the local care system was especially fragmented, with the Medicaid health plan contracting with safety net clinics, private physicians, and private hospitals. This posed challenges, as there was no large player driving expectations and practices, but also offered the opportunity to collaborate to establish guiding principles collectively.

What is HIP's role in developing a common purpose among the coalition?

HIP aligns partners to develop a common vision, and we collate what we learn from stakeholders to determine a shared strategic focus. We bring in stakeholders and lead the coalition in action toward outcomes, and we collect and analyze utilization and demographic data.

When we incorporated HIP in 2004, the partners held discussions to identify "common ground" issues that were ripe for collaboration. HIP worked diligently for five years to bring partners together and create relationships, and in 2009 HIP joined IHI's Triple Aim initiative and established the Triple Aim as our guiding framework for improving health outcomes of those served by safety net clinics, with a focus on vulnerable populations.

The Triple Aim has pushed us to see the value of data in two ways: the power to show that you are making an impact, and the power to create some pain and ignite the sense that things need to be done here — that we need to change. So, the Triple Aim has driven us to do, to act, and the fact that we are data-driven helps bring people to the table.

What are HIP's key areas of focus?

We focus our work in three interconnected areas: building systems of care, strengthening the safety net, and promoting collaboration. The Health Navigator Program is an example of how HIP built new systems of care, and we have taken a similar approach in designing programming to improve access to care and manage chronic pain. We are committed to strengthening the safety net and have convened a Safety Net Clinic Coalition (SNCC) of providers who "develop solutions to address common challenges, share expertise and best practices, and improve quality of care."

Since 2009, we have collaborated on common ground issues and largely focused our work on making health care reform (the Affordable Care Act) successful in our county, largely by increasing access to health care. We supported safety net clinics in the transformation to patient-centered medical homes, promoted coordinated outreach and enrollment in expanded health care coverage, succeeded in advocating for increased Medicare reimbursement rates (from rural to urban rates), and developed a Health Navigator Program [more details below] to help vulnerable people access care and boost their health outcomes. We incubate new programs, but we are not the provider of last resort.

HIP is a mature coalition with a clear governance structure, which requires time and care to cultivate. Will you describe HIP's governance structure?

The monthly HIP Council (HIPC) serves as a meeting place for health care leaders and other community stakeholders. HIPC has met every month at the same time, in the same location, for more than ten years. This speaks to the relationships and trust that have developed; this is not just another meeting. The HIPC agenda is developed by the Executive Committee of the HIP Board of Directors. Our collaborative progress would not be possible without this consistent, trusting forum.

The HIP Board comprises representatives of 26 member organizations and meets in person once a year, followed by a celebratory community event. The board establishes bylaws and structures for the ways in which members will contribute to initiatives. Finally, the Executive Committee has seven members, including at least two safety net leaders alongside hospital leaders, and meets monthly to closely monitor the financials and discuss policy.

What does it take to develop effective collaboration among a diverse group of stakeholders such as health care organizations, social services, local government, community-based organizations, churches, and citizen groups?

The overarching "common ground" goal — that is, for our county to be healthy, financially sound, and caring toward its population — brings people, groups, and even competing organizations together. And our focus on common issues and vulnerable populations helps us identify collaborators and find those who are willing to participate.

For each of our initiatives, which grow out of the common ground issues, we brainstorm a list of key stakeholders by asking ourselves a series of questions: Who touches the target patient population? Who does the target population affect in the health care system? What is in it for the potential partners who may join us in the initiative? Once we have answered those questions, we meet one-on-one with the stakeholders, describe the initiative to them, and ask if they are interested in participating. Now that our coalition is ten years old, and we have built good relationships and learned about our stakeholders, we are good at identifying and "hooking" them to work alongside us.

How has shared data helped the local work of health improvement, and what does it take to get data shared?

We started collecting utilization data from our safety net clinics in 2008 to analyze clinic capacity, growth, and patient demographics. Before sharing these data in a report to health care leaders and the community, we regularly present and discuss the data and its interpretation with Safety Net Clinic Coalition (SNCC) members. In 2011, the Safety Net Medical Directors decided to share with each other their quarterly Care-Based Incentive data (which they receive from the Medicaid Health Plan, including hospitalization for ambulatory care sensitive conditions, avoidable emergency department use, patients leaving one practice for another, primary care visits, and HEDIS measures). This data sharing has fueled our collaborative work to promote patient-centered medical homes in the safety net and to share best practices.

In the future, we hope to take the next giant step in data sharing and get agreement within the SNCC for HIP to collect information from clinic patients, using a secure mobile technology, on their experience of care and engagement in their care. We aim to share the data with the individual

clinic partners, with comparable data from other clinics. Data from safety net patients would support our continued work to strengthen patient-centered medical homes (PCMH). We believe that clinics will participate because these data would satisfy the National Committee for Quality Assurance PCMH recognition standard and lead to improved Care-Based Incentive payments. HIP will be seeking grant funding to launch this data-sharing program so that the survey costs are not an initial obstacle for our clinic partners.

HIP has served as a backbone organization in Santa Cruz County through a decade of financial turmoil. How is HIP funded, and is it sustainable?

While some new resources were introduced in the past ten years, such as those offered by the Affordable Care Act (ACA), local governments contracted and competition grew for philanthropic dollars. A lot of the work for HIP staff entails trying to maintain a stable funding level; we do a lot of grant writing, but even that is complicated as we make every effort not to compete with the individual safety net clinic organizations.

At the beginning, we had a federal grant through the Healthy Communities Access Program (HCAP) which provided core funding. When that ended, the county stepped in with unrestricted funding, recognizing both the value of collaboration to the community and HIP's activities in community health planning. We anticipated that federal funding of health care coalitions would be reinstated and thus advocated for this legislation with other members of Communities Joined in Action. In 2010, we asked all of our member organizations to make voluntary member contributions when it became clear that there would be no federal bailout and simultaneously the county began to reduce its funding. The Health Navigator Program was supported with in-kind contributions from Santa Cruz County and by California foundations, including the Health Home Innovation Fund and The California Wellness Foundation.

What are HIP's biggest successes?

We are really proud of our relationships with organizations and people in the community, and the collaboration we have fostered has been successful beyond anyone's expectations. Our advocacy work (alongside others) has succeeded in increasing the Medicare ambulatory reimbursement rate, and the Safety Net Clinic Coalition has increased clinic capacity by 10 percent. We have seen emergency room use among infants under the age of one drop by 29 percent, and Medicaid payments for avoidable emergency room visits decrease by $2,586 per 1,000 members. The Centers for Medicare & Medicaid Services (CMS) visited us because we have the lowest rate of use of long-term acute care by Medicare beneficiaries in the US, and CMS has an ongoing year-long study to learn more about that.

We have built "collaborative capital" over the last ten years by fostering relationships and coordinating programs with measurable accomplishments. A major test of the HIP coalition was the successful local implementation of the ACA. In Santa Cruz County, there was a 75 percent reduction in the number of uninsured residents (21,000 new Medi-Cal members and 13,000 new Covered California members in 2014). This reduction was significantly higher than in neighboring counties and in the state of California, due to public/private collaboration around outreach and enrollment. HIP's collaborative work to strengthen safety net clinics added capacity for the 21,000 new Medi-Cal members and prepared clinic staff to effectively address the complex needs of this newly insured population.

How has this collaboration and HIP's role as an incubator of new programs come to life in the Health Navigator Program?

From 2009 to 2011, HIP began Health Navigator work as a pilot with federal funding that allowed HIP to employ one community educator. We hired a bilingual, bicultural person, knowing that she would serve many Spanish-speaking patients. The community educator worked to bring everyone to the table. Partners that were involved — including the county's Project Connect program, hospitals, and safety net clinics — had a hard time understanding the details of who works with whom in each service. For example, the hospital social workers did not know the community care providers. We quickly learned that we needed wraparound team care: one community educator was not going to be able to link patients to all services they needed to support their health. The Health Navigator pilot forged those connections and developed a steering committee to guide the wraparound care.

In 2012, HIP designed the Health Navigator Program to support high-risk vulnerable people who frequently visited the emergency room and were admitted to hospital-based care. It grew out of the pilot and hospitalist work at Dominican Hospital and was designed to link unassigned, low-income, uninsured patients to our local health network. The county Health Services Agency contributed a half-time senior social worker and a 0.7 FTE nurse, and HIP coordinated the project and brought on a public health nursing consultant to guide the frontline nurse in public health strategies.

First, we developed an algorithm that designated which clinic the patient would be linked to, based on hospital admission data and patient criteria. We set up a hospitalist oversight committee that met once per quarter. That team revised the algorithm to include direct phone numbers of key care providers and community services. They also incorporated a field [in the electronic medical record] for primary care physician assignment, making it possible to flag each patient as they came into the hospital, signaling to the hospital social worker to visit the patient. The program ran for two years and we then became engaged in coordination of similar local efforts.

Quality improvement drove this project, and the Triple Aim gave us the framework to collaborate with our partners on something really complicated. We used the Triple Aim to help us figure out the data: we learned which patients to target for our services and whether or not we were having an impact on the health outcomes and utilization patterns of our patient panel. We began by working with five patients, and scaled up in a 5X method [i.e., starting with five patients and then increasing by multiples of five], reaching 25 and then 140 patients over 14 months. From October 2012 through December 2013, 140 individuals were enrolled in the Health Navigator Program and we reduced 30-day readmission rates to below 5 percent, compared to 11 percent at baseline.

We engaged in conversations with at least eight different care coordination programs that have emerged after the success of the Health Navigator Program, and we are considering opportunities for coordination, collaboration, and data sharing. We would like to envision ourselves as the organizers of local care coordination, to expand this further and further outside of health care and into the community, as funding becomes available.

What is the next iteration of this work?

In 2015, we are conducting a listening tour with our member organizations, funders, and local elected officials in the context of expanded coverage, a strengthened safety net and Medicaid health plan, and a decade of collaboration. We are asking three questions: What is your organization's vision for the local health care system in 2020? What is your organization doing to achieve that

vision? How can HIP help achieve your vision? Based on what we hear, we will propose a common agenda, metrics, and sustainable HIP activities for discussion with HIP member organizations in late 2015.

As a community, although we have responded to the initial access needs of the newly insured, we know that there is work still to be done to provide access to patient-centered care for all residents of our county. This has been a driving force behind HIP's work over the last decade and will continue to inform our focus on strengthening the safety net and convening a broader coalition to address the cross-sector determinants of health.

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