The Triple Aim: Project Prospectus for Phase 2 Prototyping

Introduction

With rare exceptions, US health care as a *system* is disjointed, inefficient, and ineffective in promoting population health and in providing full value for the resources invested. This is despite the good intentions of clinicians, health care administrators, and other participants in the system. Other developed nations receive far better value for the resources invested as evidenced by better population health outcomes, and lower per capita cost of care. The Institute for Healthcare Improvement (IHI) believes that new designs can and must be developed to accomplish three critical objectives, or the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

IHI is embarking on a second phase prototyping initiative focused on the Triple Aim, and seeks interested and capable organizations to join this effort. This document provides background and describes the activities and expectations that make up the prototyping effort. We welcome expressions of interest from a wide range of health care provider and other health related organizations. Please contact Carol Beasley at IHI to discuss this opportunity further (cbeasley@ihi.org; 617-301-4838).

The Triple Aim

IHI's innovation team has developed a concept design and described an initial set of components of a system that would fulfill the Triple Aim. The five components are listed below, and a more detailed list of the components is provided in Appendix A.

1. Focus on individuals and families;
2. Redesign of primary care services and structures;
3. Population health management;
4. Cost control platform;
5. System integration and execution.

The Triple Aim concept also includes roles for "macro" and "micro" integrators. The macro integrator is not necessarily a new structure or organization, but rather an entity that can pull together the resources to support a defined population, and make sure that the system is optimized for the sake of the defined population. The macro integrator works with, and helps to improve the front-line systems that support

individuals. The micro-integrator is the person or team that makes sure that the best and most appropriate care is provided to individuals. In effect many individuals act as their own micro-integrators. A primary care team or "medical home" could fulfill this role as well, and there are likely to be other workable approaches to micro integration.

Prototyping Activities—Phase 1

Between October 2007 and April 2008, IHI worked with a group of fifteen organizations committed to implementing the five design components of the Triple Aim. Each organization had already adopted strategic aims that were aligned with the Triple Aim, and each saw itself as fulfilling the role of a system (or macro) integrator of care. The organizations encompassed significant diversity, comprising hospital-centric integrated health systems, systems that were fully integrated in both the delivery and financing of care, safety net systems, grass-roots coalitions, public health systems, single-payer national systems, and health plans. They also span many geographic regions, and among them serve highly diverse populations. A list of the participating sites is provided in Appendix B.

Each site selected at least one defined population for focus, determined what changes it would test, and adopted a balanced set of measures to use in assessing whether the changes led to improvements in the Triple Aim elements.

Some of the most promising areas of testing undertaken by the teams have been:

- The use of predictive modeling to identify patients who are likely to need intensive services so that their needs can be met proactively.
- Redesign of primary care services including:
  - Making appropriate care services available around the clock, thereby reducing the need for emergency department visits and other acute care
  - Using health risk assessments and health coaches to better catch and manage health problems when they are simpler to treat
- Using individual cases to stimulate the design of more effective, patient-centered, and less wasteful services.
- Collaboration with purchasers of care to improve care and outcomes for defined populations, whether private sector, such as the employees of a company, or public sector, such as Medicare/Medicaid patients with HIV/AIDS.
- Partnering with community-level organizations that share the goal of improving health.
- Reducing avoidable use of emergency care by understanding the frequent emergency department patients.
- Translating the goals of the Triple Aim into proposals for payment reform.

Prototyping Activities—Phase 2

IHI is currently seeking a larger group of organizations whose missions are aligned with the Triple Aim, and who see themselves as "macro-integrators." Several types of organizations can fulfill this role including integrated systems, hospital based systems, state and county-based initiatives, academic

medical centers, safety net providers, municipal or regionally-based public health departments, social services organizations, community based HMO's, businesses, and teams from other countries including those with publicly funded or single-payer systems.

Scope and Aims

Starting in summer 2008, and continuing for through May 2009, we will launch an expanded prototyping effort, building on the first phase. The goals for the next phase of prototyping are:

1. Accelerate the progress of the participants on their strategic initiatives related to the Triple Aim;
2. Develop innovative services and delivery models to achieve the Triple Aim;
3. Strengthen the approach to measuring the Triple Aim components in a balanced and practical way;
4. Build understanding of how large systems can transition toward Triple Aim-based models of care while remaining organizationally and financially viable.

At an individual team level, we will expect each team to:

- Designate a defined population that they will work on;
- Identify four to six critical measures of success;
- Incorporate specific Triple Aim elements into their design of care;
- Demonstrate how these activities are connected to the organization's overall mission and strategy;
- Confirm with run-chart and other data the results of the changes they choose to implement.

Activities

Coaching: When a team joins the prototyping initiative, they will be connected with a coach who will provide support throughout the prototyping period: Activities include:

- An initial coaching call to review the Triple Aim concept design, the role of the macro-integrator, and the five design elements. The coach will help the team select its focus population and begin to describe more fully which design elements they will implement. The coach will help the team plan its initial activities with an emphasis on learning from and working with the individual, and using their learning to redesign primary care.
- During the prototyping period, the coach will talk with the team approximately monthly, helping the teams to integrate new design concepts, connecting them with other teams doing related work, supporting them in strengthening their design, testing, and execution activities.

On-Site Visits: During the prototyping period faculty members will make a limited number of on-site visits. Sites interested in having a visit will request this of the faculty and must be able to show a well-formulated Triple Aim design for their site, along with run charts of relevant data. Site visits will be publicized to all the participating sites, and visitors from other sites are encouraged to attend, within the space constraints of the hosting organization.

All-Team Meetings: There will be two all-team meetings, one in Fall 2008 and the other in Spring 2009. In these meetings the teams will present the designs they are testing to the faculty and to each other, and

gather suggestions from the faculty and other teams on how to strengthen their testing of new designs and the full execution of these designs.

All-Team WebEx Sessions: Once or twice per month there will be a one-hour WebEx session which will explore specific Triple Aim design concepts in greater depth, offer advice on effective measurement, and provide coaching on successful execution of system change. On each call at least one site will have an opportunity to present its work and receive active coaching and recommendations from the faculty and the other sites.

Opportunities for Research and Development: IHI has an active program of research and development which is organized around 90-day cycles. Topics relevant to the Triple Aim are included in each cycle and participating teams will be given the opportunity to participate in projects where aligned with their interests and capabilities.

Expectations of the Participating Sites

Senior Leadership Support: Because of the strategic and system-level focus of the Triple Aim, participating sites must have the full support of their senior leadership. We recommend that the senior leader stay actively connected to the team's work. Ideally this project will be a recognized priority at the board of trustees' level.

Dedicated Project Resources: The senior leader should be able to appoint a high-level project leader to oversee the day-to-day activities, someone who has dedicated time for this work. This should not be difficult as long as there is a strong link between their organizational strategy and the Triple Aim.

Innovative Approach to Measurement: Since per capita health care cost and the health of the population are not typical measures for health care providers, some organizations will have to develop new ways to collect and use data, including looking beyond their own data systems to external sources.

Partnering and Inclusion: As the macro integrator, the organization will need to reach beyond its usual boundaries to develop partnerships within its community. Partnering relationships could include health care organizations and groups such as social service agencies, local governments, public health departments, educational institutions, civic, religious, and other non-profit or voluntary organization focused on improving the health of the community. We also expect participating sites to include patient, family, and community representatives as active team members.

Engaging with the Triple Aim Prototyping Initiative

As with the first group of prototyping teams, we are seeking to engage organizations that have already incorporated Triple Aim thinking into their strategic plans or plan to do so within the next five years, are actively engaged in work that addresses the Triple Aim, and are willing to commit to designating a population for additional design focus and testing.

We intend to maintain and build upon the diversity that characterized our first group of prototype sites. Organizations that we believe could be well-suited to join the prototyping effort include:

- Large hospital-centric integrated delivery systems
- Large integrated care systems such as HMOs that encompass both the financing and delivery systems
- Large physician group practices
- Health plans
- Federally Funded "public sector" organizations
- International groups in fixed funding environments
- Public Health departments
- Employer-based health systems
- Consumer/patient advocacy groups
- Community services or community-based health-related services
- Innovative care delivery organizations, such as pharmacist-run clinics, school-based systems, housing-based systems
- Other organizations with the will and capability to fulfill the Triple Aim.

Organizations that are well-suited to participate in the Triple Aim prototyping initiative typically have the following characteristics:

1. The executive team sees that the Triple Aim is, or will be, strategic for their organization. It may not be the complete strategic focus for today but it must be strategic within the next five years.
2. The organization can clearly define the population that they are caring for now and have a vision for the populations they hope to impact over the next five to ten years
3. The organization is willing and able to act as the macro integrator and can describe how they will:
    a. Obtain the entire range of services needed for a population
    b. Organize the range of services needed
4. The organization has a proven track record of executing significant health care improvement and even organizational transformation. They are skilled and agile in using the Model for Improvement or other similar model, running small tests of change, and implementing change on a large scale.
5. The organization will have the capability to work closely with the micro integrators who provide primary care to their population.

Cost to Participate

Teams may join any time between May and September 2008, and their active participation will start as soon as they join the project. The cost to participate is $18,000. In addition, organizations should be willing to dedicate staff resources including time and travel expenses to participate in project activities.

Appendix A

Some Components of a System to Accomplish the Triple Aim:

1. Individuals and families

- For medically and socially complex patients, establish partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among multiple providers of care.
- Jointly plan and customize care at the level of the individual targeted to the best feasible outcomes.
- Actively learn from the patient and family to inform work for the population.
- Enable individuals and families to better manage their own health

2. Redesign of "primary care" services and structures

- Have a team design for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
- Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
- Cooperate and coordinate with other specialties, hospitals, and community services related to health.

3. Population health management

- Efficiently customize services based on appropriate segmentation of the population using a health risk assessment tool or equivalent.
- Use predictive models that take into account situational factors and medical history to deploy resources to high-risk individuals.
- Work with the community to strongly advocate for smoking prevention, healthy eating, exercise, and reduction of substance abuse.
- Set and execute strategic initiatives related to reducing inequitable variation in outcomes or undesirable variation in practice.

4. Cost control platform

- Achieve 1-3% inflation yearly for per capita cost by developing a strong relationship with a group of specialists committed to reducing overuse of unnecessary health care and who focus on care coordination with families and the rest of the health care team.
- Achieve lowest decile performance in the Dartmouth Atlas measures by breaking or countering incentives for supply-driven care.
- Reward health care providers, hospitals, and health care systems for their contribution to producing better health for the population and not just producing more health care.

5. System integration

- Match capacity and demand for health care and social services across suppliers.
- Insure that strategic planning and execution with all suppliers including hospitals and physician practices are informed by the needs of the population.
- Develop a system for ongoing learning and improvement.

Appendix B

Triple Aim Participating Sites:

Hospital-based systems:

- Cincinnati Children's Hospital Medical Center, Ohio
- Bellin Health, Wisconsin
- Genesys Health, Michigan

Integrated health systems:

- Group Health, Washington
- Health Partners, Minnesota

Health Plans:

- CareOregon, Oregon
- New York-Presbyterian System SelectHealth, LLC, New York

State-wide initiative:

- Vermont Blueprint for Health, Vermont

Safety net:

- CareSouth Carolina, South Carolina
- Contra Costa Health Services, California
- North Colorado Health Alliance, Colorado
- Primary Care Coalition of Montgomery County, Maryland
- Queens Health Network, New York

International

- Jönköping County Health System, Sweden
- Bolton Primary Care Trust, UK England