IHI Triple Aim Improvement
Community
Informational Call
June 12, 2012
Welcome to today’s informational call!
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Today’s Presenters

Carol Beasley, Executive Director

John Whittington, Faculty
Agenda

- Introduction to the IHI Triple Aim
- Populations of Focus
- Aim and Intended Results
- Priority Content
- Measurement
- Learning Design and Activities
- Expectations of Participating Sites
- Questions
Three Dimensions of Value

- Population Health
- Experience of Care
- Per Capita Cost
Triple Aim

- “Better care for individuals – as described by all six dimensions of quality in the Institute of Medicine report: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity;”

- “Better health for populations with respect to educating beneficiaries about the upstream causes of ill health – like poor nutrition, physical inactivity, substance abuse, economic disparities – as well as the importance of preventive services such as annual physicals and flu shots; and”

- “Lower growth in expenditures by eliminating waste and inefficiencies while not withholding any needed care that helps beneficiaries”
Design of a Triple Aim Enterprise

Define “Quality” from the perspective of an individual member of a defined population

The “Triple Aim”

- Health care
- Public health
- Social services

Per capita cost reduction
Integration
Social Capital
Capability Building

Definition of primary care

Individuals and families

System-Level Metrics

Prevention and Health promotion

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Achieving Triple Aim Results

• Purpose
• Measurement/intelligence
• Portfolio of projects and investments
• Integration and governance
Triple Aim Prototyping Sites
Identifying a Population

• Health care struggles to define a population. Often a health care team focuses on a disease.

• The Triple Aim is about learning strategies that apply to a population for which you hold yourself accountable for improving health and per capita cost while continuing to manage the experience of care.

• We now see movement in the US about caring for populations such as Accountable Care Organizations.

• Organizations outside the US tend to think more about populations at a regional level.
Poll #1: Do you currently focus your organization’s activities on the needs of populations, and improving population results in health, care, and cost?

- **Yes**: We understand our population as a whole and we have identified segments with common needs that we can use as a focus for improving care designs and results.

- **Somewhat**: We are able to do some basic segmentation of our population, and are starting to think about how to serve the needs of our segments.

- **Slightly**: We are aware of the needs of particular segments, such as diabetics or children with asthma, but we are not actively testing new designs.

- **No**: We have minimal ability to identify population segments or to test new care designs for specific segments.
Triple Aim Populations

1. A defined population that makes business sense to improve health, improve care and lower cost.

2. A community-wide population for which you can work to solve a health problem and create a sustainable funding source.
Defined Populations

1. It makes “business” sense for you to choose this population.

2. You can explain why you will hold yourself accountable for all three aims.

3. You want to learn how to manage a population and choosing this population will help you.
Defined Population Examples

• Employees
• Members of a health plan
• All the individuals who use a particular FQHC
• All the uninsured who use a hospital’s ER
• ACO or other fully integrated system
Triple Aim Workstreams

1. A defined population for which it makes business sense (to your organization) to improve health, improve care and lower cost.

2. A regional or community population on which you can work to solve a health problem and create a sustainable funding source.
Regional/Community Populations

1. The solution requires addressing multiple determinants of health including but not limited to health care.

2. The potential health care contribution to the solution of the problem is not too small. Both treatment as well as prevention are included and are within reasonable boundaries of what is expected of health care.

3. The population of interest is defined by geographic boundaries - anyone living within the boundary is in the population whether or not they are currently engaged with the health care system.
Regional/Community Population Examples

- Children in Hamilton County with asthma
- Premature birth in Essex County
- African American males in the greater-Memphis region with undiagnosed hypertension
- Chronic disease with mental health co-morbidity in Minneapolis
- Frail elderly in a dense “retired-in-place” community in New York City
Aim and Expected Results

Every site will:

• Build a robust Triple Aim infrastructure for measurement and improvement.
• Define and advance key projects within their portfolio to achieve measurable project results.

Some sites will:

• Attain positive results on all three aims, at least for a pilot population of strategic importance.
Key Milestones

• Selection of one or more populations (or segments) of focus
• Establishment of a robust infrastructure for executing projects and initiatives based on Triple Aim strategies
• Development of specific “how good by when” population aims and use of corresponding measures to track progress
• Selection and execution of a set (or portfolio) of inter-related projects that in concert can achieve results
## Portfolio of Projects and Investments

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Typical projects</th>
<th>Typical investments</th>
<th>Capability building</th>
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<tbody>
<tr>
<td>Regional intelligence</td>
<td>Data from ambulances, data from EDs</td>
<td>Fund a few positions to receive, maintain, and analyze the data for the community</td>
<td>Timely knowledge of community health status</td>
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<td>Primary care</td>
<td>Redefinition of primary care</td>
<td>Connections with community resources</td>
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<td>Longitudinal experience of care</td>
<td>Care for the socially complex</td>
<td>Community based health promotion and care mgt.</td>
<td>Development of new skills in the workforce</td>
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<td>Payment and cost control</td>
<td>Improving health and lowering cost for employees</td>
<td>Health risk appraisals, and health coaching</td>
<td>Driving cost savings through population health</td>
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<td>Community health</td>
<td>Falls with harm in the community</td>
<td>Integration of existing efforts, ACO savings</td>
<td>Cooperation, improvement skills, joint investing</td>
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Poll #2: Are improvement projects at your organization aligned with a Triple Aim?

- Yes: We have intentionally chartered a group, or “portfolio,” of improvement projects that together will move our population toward all three dimensions of the IHI Triple Aim.

- Somewhat: We try to include Triple Aim thinking in some of our projects, but we don’t currently manage them as a portfolio of related work.

- Slightly: We talk about a Triple Aim when we charter projects, the projects are not connected in a Triple Aim portfolio.

- No: We do not organize our improvement projects around a Triple Aim at this time.
Priority Content

• Defined Populations Workstream:
  — High risk, high cost individuals
  — Employee populations

• Regional/Community Populations Workstream:
  — Medically and socially complex individuals
  — Care for the frail elderly
  — Community activation
# Potential Triple Aim Population Outcome Measures

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<th>Dimension</th>
<th>Measure</th>
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| **Population Health**| 1. Health Outcomes:  
   - Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates  
   - Health/Functional Status: single question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12)  
   - Healthy Life Expectancy (HLE): combines life expectancy and health status into a single measure, reflecting remaining years of life in good health  

2. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions  

3. Risk Status: Behavioral risk factors include smoking, alcohol, physical activity, and diet. Physiological risk factors include blood pressure, BMI, cholesterol, and blood glucose. (possible measure: a composite Health Risk Appraisal (HRA) score) |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Experience of Care**| 1. Standard questions from patient surveys, for example:  
   - Global questions from US CAHPS or How’s Your Health surveys  
   - Experience questions from NHS World Class Commissioning or CareQuality Commission  
   - Likelihood to recommend  

2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered) |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Per Capita Cost**   | 1. Total cost per member of the population per month  

2. Hospital and ED utilization rate and/or cost |
Systems of Measurement: Example Project Measures

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<tr>
<th>Project</th>
<th>Project Measures</th>
<th>Impact on Triple Aim</th>
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<td>Smoking cessation</td>
<td>• # of people contemplating a smoking cessation class (Process)</td>
<td>Population Health: Improved self-assessed health and reduction in disease burden</td>
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<td>• # or % of people who have stopped smoking (Outcome)</td>
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Poll #3: Does your organization measure its results around all three dimensions of the IHI Triple Aim?

- **Yes**: We have reliable metrics around all three aims.
- **Somewhat**: We have reliable metrics around one or two of the aims, and at least proxy measures around others.
- **Slightly**: We are beginning to measure all three aims in at least a segment of our population.
- **No**: We do not currently measure these three elements for our population.
Learning Design: Our Approach

• Getting Started
  — Assess organization or coalition’s readiness
  — Gather intelligence

• Testing and Applying Change Ideas
  — Begin by addressing population segments with high complexity and high cost

• Scale-up and Spread
  — Disseminate and implement better practices across more settings or for a larger population
# Learning Design: Program Activities

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Expectations of Participating Sites

• Triple Aim is a strategic priority supported at the senior level
• Meaningful populations (or segments) can be identified for improvement
• Key partners will need to be engaged
• Commitment to developing data capabilities to generate measures for all elements of the Triple Aim
• Participants have skills in executing improvement initiatives
• Resources are dedicated to driving progress on the site’s Triple Aim project portfolio (project management, data analyst, executive oversight, etc.)
Questions?

Contact Kathryn Brooks at kbrooks@ihi.org with questions or to enroll.