INSTITUTE FOR HEALTHCARE IMPROVEMENT

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**SUMMARY REPORT: 90-DAY PROJECT**

**Triple Aim Region: The Fourth Cycle**
7/31/11

## *Executive Summary*

Since embarking on the original IHI Triple Aim initiative in 2006, the impact of our work is increasingly visible. Formerly discussed only within the initiative and in IHI circles, the Triple Aim has become part of the strategic framework for many organizations, coalitions, and health systems around the world. In the United States, it is now a guiding principle at the Centers for Medicaid and Medicare Services (CMS), and is embedded in new payment strategies such as Accountable Care Organizations (ACOs). The first year of work thinking through how to achieve the Triple Aim in a geographic region has led to considerable progress in several regions of the United States to develop explicit regional purpose, articulate specific regional aims for health, care experience, and cost, assemble a portfolio of projects, and begin the process of active implementation.

An important role for the IHI team in supporting the regions pursuit of the Triple is articulated in the following seven-part outline:

1. *Initial contact.* Initial contact begins with a dialogue between the community or region and IHI to gauge their intention and their understanding of the Triple Aim.
2. *"Casing the Joint."* The IHI team visits with their leadership onsite to understand the dynamics of the community, including key regional players, level of support within in the community, and how IHI should work with the community.
3. *Boot camp for Triple Aim Principles.* Engaging new teams in on-boarding activities such as the IHI Triple Aim two-day public seminar has proven valuable, as have learned that communities need help in understanding the Triple Aim and how to work with it at a regional level, integrating many disparate stakeholders and existing efforts.
4. *Community Asset Assessment.* It is through a community asset assessment that we find out what the community has been working on that applies to the Triple Aim.
5. *Purpose, Measures, Portfolio and Integration.* Through our work to date on the Triple Aim, we have found that four key elements, purpose; measures; portfolio and integration, have proven foundational to working with a community. These elements were initially introduced and well described in the R and D paper by Tom Nolan, “Achieving the Triple Aim in Geographic Regions: Looking Ahead.”
6. *Execution - pulling the trigger, forming workgroups.* Once a region has established a clear purpose, identified system-level regional measures, a portfolio of projects, and a sound and sustainable structure to govern the work, they now need to actually start the

work on projects. Some projects are already underway by other organizations and the Triple Aim coalition needs to figure the best way to help accelerate and integrate the work.

7. *Development of a learning system.* Development of a learning system is tied closely to execution. Individual organizations may have many of the pieces of a learning system, but it is doubtful that the community will have such a learning system in place. Therefore this will need to be developed to do this work.

The execution step is where three of the communities are right now. Each community has worked through purpose, are considering global measures, have identified a set of projects for their portfolio and are working on integration and governance. They are now grappling with launching their work on projects. We have found that although the regions have high level leadership and governance structures, they do not have the key personnel who can do the work at the project level, such as those with project management skill, community organizing and deep quality improvement skill, and the time to accomplish this work. They need both a learning system for the project plus a community wide learning system for the portfolio. The challenge is to take these same skills and use them at a community level, which in many regards is magnitudes of complexity over the work that is done within one organization. *Our intended focus for the next year of the regional initiative will be on helping sites build a sustainable infrastructure for execution of their portfolios, as well as a learning system for scale-up within their regions.*

**I.Research and Development Team:**

- Leader: John Whittington
- Colleagues: Ninon Richartz, Zoe Sifrim, Martha Rome

II.**Intent:**

This wave will build on the work of three preceding Research and Development cycles that have focused on achieving the Triple Aim in a geographic region: August - October 2009; November 2009 - January 2010; and August - October 2010. Based on this work, we developed an overall framework focused on purpose, measures, a portfolio of projects and governance/integration. A set of tools was developed to support this framework. Our intent for this cycle is to test and refine this framework and tools so that we can support geographic regions that want to achieve breakthrough results on all three aims.

A secondary intent of this work is to understand the various experiments currently underway within the US such as Patient Centered Medical Home (PCMH), accountable care organizations (ACO), the ONC-funded Beacon Community Program, and the Community-Based Care Transition supported by CMS, to see how they might inform our work on the Triple Aim and how we might impact them.

**III.Background:**

The Triple Aim is now in its sixth year from concept to action. A lot has changed from the first time the Triple Aim was suggested to the IHI Board of Directors in 2005 until now. Many organizations and coalitions around the world now embrace the Triple Aim as a framework for thinking about health, health care and cost. A recent CMS initiative focused on the Accountable Care Organization goes so far as to mention the three aims over ten times in its rules and regulations. Our work since 2005 shows that the Triple Aim has been tested in diverse settings around the world and has been successfully used as a strategic framework.

But there is still much to learn, particularly at the regional level for the US. We are currently working with a core group of regionally-focused sites which continues to provide a wonderful partnership to advance their work while informing our future efforts. Recent work has helped us test the framework of purpose, measures, a portfolio of projects and governance/integration, and we have seen firsthand the challenges of taking on this on. For example, some teams struggle with the formation of a clear purpose for their work, while others want to immediately jump down to the project level. We recognize the need to learn how to identify and prepare teams to work with this framework.

In addition, even when an organization understands and is working through the framework, we find they often struggle with the design of their portfolio of work. For example, sites continue to struggle with work that will impact cost at a regional level. Often they think that if they can just improve health or manage a particular chronic disease well, they can improve the cost of health care for the region. However, we have found that hoping that health promotion and better chronic disease management will "bend the cost curve" is unrealistic, as there is little evidence of this at the regional level. To manage cost you need to work on new financial models that pay for managing health and not just producing health care. Otherwise, we believe they are simply "squeezing a balloon" - as soon as costs are controlled for one segment of the population by exclusively focusing on health improvement, costs will bulge out elsewhere. There are many interesting experiments for managing cost going on at this time including the ACO, new payment models for primary care and new insurance payment initiatives like the Blue Cross and Blue Shield alternative quality contract. So far, this approach has helped confirm the importance of developing purpose, measures and a portfolio around all three components of the Triple Aim.

Ultimately what we are doing is partnering with regions around the Triple Aim to develop breakthrough results such as decreasing the rate of health care growth to CPI levels, improving care coordination so that readmissions become rare, and producing health outcomes that are measurable around such things as years of productive life lost.

The following list of sites includes at least a partial geographic focus in the US. Not all sites that are part of the IHI Triple Aim prototyping community are focused on a geographic region and thus

are not included in this list. Additionally, there may be several Triple Aim sites that are working at a regional level and have been overlooked in this list.

- Allegiance Health (MI)
- Bellin Health (WI)
- Cincinnati Children's Hospital Medical Center (OH)
- Erlanger Health System (TN)
- Genesys Health (MI) (Ascension)
- St. Charles Health System (formerly Cascade) (OR)
- Contra Costa Health Services (CA)
- Health Improvement Partnership of Santa Cruz
- County (CA)
- Hidalgo Medical Services (NM)
- North Colorado Health Alliance (CO)
- Memphis, TN
- Primary Care Coalition Montgomery County (MD)
- Queens Health Network (NY)
- Regional Primary Care Coalition (MD)
- Blue Cross Blue Shield of Michigan (MI)
- CareOregon (OR)
- HealthPartners (MN)
- Pueblo Health Department (CO)
- Vermont Blueprint for Health (VT)
- Cedar Rapids, IA
- Michigan Health Information Alliance (MiHIA)
- Asheville, NC/Western North Carolina Health Network

**IV.Description of Work to Date:**

1. *Work with the present Triple Aim Regional sites to understand and test our theories and tools.* The IHI team conducted a set-up site visit to the Memphis, held a face-to-face meeting with Triple Aim sites in Denver, CO, and have continued to support MIHIA, Memphis and Asheville regional sites. Observations from this work were used to expand a working model to support regional organizations. We also tested our regional assessment tool. (Additional discussion on these models and tools is included in Appendix E.)

2. *Analyze and report back the main opportunities and challenges with the ACO and how they link to the Triple Aim.* The IHI team held three meetings with teams that are currently pursuing an ACO and developed an issue list from this work. The team also reviewed much of the CMS March 31 proposal on ACO. (Additional discussion on these models and tools is included in Appendix C.)

3. *Conduct an analysis of health care productivity.* This included an exploration of a potential measurement system, as well as the development of a toolkit that would

estimate what you get for various investments. The team broke this effort his into two parts: first an estimate and then the menu of ideas to select from. Additionally, Zoe Sifrim focused on health care's contribution to health. (Additional discussion on these models and tools is included in Appendix A.)

4. *Support activities for the Triple Aim.* This effort included:
   - Triple Aim site recruitment plan development, lead by Ninon Richartz and Martha Rome (included in Appendix B).
   - Triple Aim in a Region white paper development, lead by Tom Nolan and Ninon Richartz.
   - Cross Program learning with the Beacon Community Program: John Whittington attended Beacon Community all-site Clinical Transformation meeting in Denver, CO. Joanne Lynn is faculty to the Beacon Community Program on care coordination and Carol Beasley and Ninon Richartz are actively supporting the Program.

## V.Results of the 90-Day Scan:

### *Sequencing Support to Communities Pursuing the Triple Aim*

Below is an outline of how the IHI team has been working with communities/geographic regions to support them on the Triple Aim. It is based on field testing a framework/model from previous R and D work and building upon it.

### 0. Initial Contact

Initial contact begins with a dialogue between the community or region and IHI to gauge their intention and their understanding of the Triple Aim. We begin to share some of the principles of this work with them, as well as our learning to date on the unique challenges and opportunities of working within a community or region. This process normally occurs over several months. We are mutually determining if this will be a good fit for them and us.

- *From the community's perspective:* Can IHI accelerate the work they are doing? Does IHI have the talent and tools to advance and add value to their work?
- *From the IHI perspective:* Does this team have the potential and will to work on the Triple Aim at a community level? We are looking for communities that have the will to work on all three aims, the potential governance structure to manage and integrate a portfolio of Triple Aim projects, and the leadership strength to accomplish this work. Each of the communities we are working with, including Cedar Rapids, MIHIA, Memphis, and Asheville has started with this step.

### 1. "Casing the Joint"

Once a community has shown significant interest in joining with the Triple Aim initiative, it is our preference to visit with their leadership onsite to understand the dynamics of the community:

- Who are the key players?
- Who is supportive?
- Who has something to lose? etc .
- How should we work with them? Should we have a kick off meeting or just work with individuals and stay in the background?

### 2. Boot camp for Triple Aim Principles

Through our work we have learned that communities need help in understanding the Triple Aim and how to work with it at a regional level, integrating many disparate stakeholders and existing efforts. In April we offered a public Triple Aim seminar which a number of people from current and past Triple Aim teams and some from prospective new teams attended. From our observations, as well as the feedback from participants, the seminar seemed to help them find grounding in basic Triple Aim principles. It also was a place for teams to start working together on their purpose, measures and portfolio of projects. For example, a prospective regional team from Memphis sent a group of representatives to the seminar, and the meeting seemed to help them start the work and developed a common vocabulary to work with us.

### 3. Community Asset Assessment

It is through a community asset assessment that we find out what the community has been working on that applies to the Triple Aim. In Memphis we had three community round tables in which people shared at a high level their work and accomplishments. MIHIA has done extensive surveillance to understand ongoing community projects. This assessment is at least a two-step process. First, do a high level survey of community activities which provides insight into what work has gone on and the leadership around this work. At this stage we are looking for projects where collective action might accelerate their work. We are also looking for places where there is limited work in parts of the Triple Aim such as in the area of per capita cost where new work needs to be introduced.

The second round of assessment needs to look in more depth at the promising collective opportunities identified in the initial high-level survey. A one-page report needs to be created for each project that includes: aims (how much by when), measures that should be displayed over time to assess the work, change ideas that have been tested and a few examples of tests that have been tried recently for this work. It should also include the day-to-day leader of this work and what percentage of their time is devoted to this opportunity.

## 4. Purpose, Measures, Portfolio and Integration

Through our work to date on the Triple Aim, we have found that four key elements, purpose; measures; portfolio and integration, have proven foundational to working with a community. These elements were initially introduced and well described in the R and D paper by Tom Nolan, "Achieving the Triple Aim in Geographic Regions: Looking Ahead." An IHI white paper on working on the Triple Aim in a region will soon be ready that will describe these items in further detail.

We have run several meetings with communities using this framework over the last year and it has served us well. A few observations from the use of this framework with communities follow below.

- *Communities seem to struggle to address the "why" in the purpose statement.* It is wonderful to say you will work on all three aims for a community but the question is, "Why is this important to the community? Without a significant reason on "why the Triple Aim is important" to this community we worry that when conflict arises, which it will, the coalition will not be strong enough to withstand the conflict.

- *Communities hunger for measures that are meaningful to them at the community level.* The good news is that there is a wealth of publicly available measures to support them. These are detailed in the aforementioned R and D paper. In addition, the Commonwealth Fund is developing a set of Triple Aim measures at the Hospital Referral Region that should support this work. Creating a small dashboard of high-level measures will be important for these communities, as no community that we have worked with so far has such a dashboard in place. Consequently we have produced a starter set of community measures for each community that we have engaged with. (include an example that we have prepared in the appendix)

- *Portfolio development has seemed to progress along the following path in all communities:* Each community begins with an assessment of community work as described earlier, looking for projects where collective action might help accelerate their work. At the same time they look for areas in the Triple Aim where nothing is being done within the community and then add projects to round out the portfolio. With work that is already underway, the next question is where the Triple Aim community coalition can add value. If an existing community project has clear aims, measures, changes ideas, strong day-to-day leadership and has been able to integrate the work with other community organizations, then the Triple Aim coalition might create more friction than value. However if many of these components are missing, this may be a project where value can be added by using the coalition.

So far we have seen many projects at the community level which are focused on improving the health of the community, some projects focused on health care experience and less on per capita cost.

- *Per Capita cost is the area on which it is hardest to gain traction.* Traditionally, there are three assumptions that are held about how to control health care cost. One is to keep the healthy, healthy and that will help with cost. The second is to manage the sick better, particularly those with chronic disease and that will help keep costs down. The third is to have the intent to control cost and develop financial mechanisms such as new payment models to control cost. Providers in most communities seem to focus on the first two and not on the third. It is our belief that the best strategy would be to have the intent to control cost and then focus on all three strategies: keep the healthy, healthy; manage chronic disease well; and develop mechanisms to control cost also on a global basis through new payment models. If you don't work on all three, it can be likened to squeezing a balloon: As soon as you get cost under control for, say Coronary Artery Disease, a new and expensive technology will come along with little impact on the health of the population and the per capita cost for the community will dramatically rise without significant impact on the health of the community.

- *Once a portfolio is created, the communities are struggling to understand their role in this work.* More of this will be discussed under execution.

- *Integration and governance are key issues for these communities.* Again, it goes back to where collective action can make a difference for the community around the Triple Aim. One community had approximately 41 organizations working on infant mortality with little to no progress made on improving infant mortality. Yet we suspect if you asked each organization if they held themselves responsible for improving infant mortality in that community they would say no. What they held themselves responsible for was a process step and not the whole. Integration of this work would mean that each organization would say yes to holding themselves responsible but also acknowledging that they cannot do this alone.

Finally, a few observations about governance: The communities with whom we are working either build new governance or identify preexisting governance structures to work through on all three components of the Triple Aim. Communities often have some governance structures in place which focus on health. However, seldom do they have governance that is simultaneously pursuing the Triple Aim. Now that they have this governance in place, they can now begin identifying work for their portfolio.

## 5. Execution

The execution step is where three of the communities are right now. Each community has worked through purpose, is considering global measures, has identified a set of projects for their portfolio and is working on integration and governance. They now need to actually start the work on projects. Some projects are already underway by other organizations and the Triple Aim coalition needs to figure the best way to help accelerate and integrate the work. Some projects are going to be new and this will require a new infrastructure to get started. As one leader recently said, "I know what I am aiming at, now I just need to pull the trigger."

The leaders of the Triple Aim coalition in these communities understand how to get projects accomplished within their own organization. They even know how to do projects with multiple organizations where a "deal" is involved, such as deciding on using a shared helicopter service or a joint purchase. What leaders of the work are not as familiar with is when the project crosses multiple boundaries and involves developing a shared learning system.

## 6. Development of a learning system

Development of a learning system is tied closely to execution. As described by Tom Nolan, the learning system should have the following components:

- System-level measures
- An explicit theory or rationale for system changes
- Segmentation of the population
- Learning by testing changes sequentially
- The use informative cases: "Act for the individual learn for the population"
- Learning during scale-up and spread
- Periodic review of this work

Individual organizations may have many of the pieces of a learning system, but it is doubtful that the community will have such a learning system in place. Therefore this will need to be developed to do this work.

## 7. IHI Support

IHI has helped three communities move through the following steps: Initial contact; "Casing the Joint; "Boot camp for Triple Aim Principles; Community Asset Assessment; and Purpose, Measures, Portfolio and Integration.

We are now into the work of helping communities execute their portfolio of projects and develop a learning system to support this work: *How does IHI do this?*

One way to think about how we can help comes from Tom Nolan's work on a Model Portfolio of Projects.

> "The following table (which has been abridged for illustration purpose from the original) provides some examples of the elements of a portfolio. The first column of the table contains the five major initiatives suggested for a model portfolio. The second column lists projects that might be executed to make progress on the initiative. The third column gives examples of typical investments that would be needed to achieve the initiative or support the projects. The fourth column indicates what capability the region would be building as a sustainable asset for use in other initiatives or projects."

What our communities have done so far is to identify projects, but they have not considered what they might need to invest in and what capabilities they will need to accomplish this work. Although they have a high-level leadership structure at the governance level, they do not have the key personnel who can do the work at the project level. They need a working team that has project management skill, community organizing and deep quality improvement skill, and the time to accomplish this work. The team needs to create specific aims, measures, and changes ideas and to run tests of these ideas at the project level. it needs to set up the project, coordinate activities , set the tempo and report out measures of progress on a regular basis. They need both a learning system for the project plus a community-wide learning system for the portfolio. In addition, it is our belief that the community also needs a day-to-day leader for the entire portfolio that has many of the skills listed above. There are people in any community who understand quality improvement work within the confines of their own organization such as a hospital or factory. The challenge is to take these same skills and use them at a community level.

| Initiative | Typical Project Aims | Typical Investments | Capability Building |
|---|---|---|---|
| *Regional Intelligence* | • Develop a data pooling strategy for insurance claims to monitor utilization and cost<br>• Use ED data to set priorities | • Fund a few positions o reallocate staff to receive, maintain, and analyze the data, and produce reports for use by the community | • Timely knowledge of community health status<br>• |
| *Primary Care* | • Reduce cost and improve care for socially complex patients by coordinating multiple providers | • Jointly financed community care mangers such as those in Vermont or the District Nurses in England and Sweden | • Cooperation and trust to develop shared resources<br>• |
| *Longitudinal Experience of Care* | • Reduce hospital readmission rates for chronic disease<br>• | • Jointly financed community care mangers such as those in Vermont or the District Nurses in England and Sweden | • A rationale for when to cooperate and when to compete with others<br>• |
| *Payment and Cost Control* | • Reduce overall cost by setting spending targets and developing an early warning system for special cause variation in cost using pooled claims data<br>• | • Infrastructure investment to design and maintain a system to set spending targets, monitor progress, and make real time adjustments. The Hospital Services Cost Review Commission in Maryland is one model. The cost control mechanism in an insurance company is another. | • Shared understanding of waste in health care<br>• Business models that allow financial gain and sustainability for innovators<br>• Regional culture of increased participation of individuals in their care |
| Community Health | • Increase healthy behaviors including smoking, nutrition, and exercise<br>• | • Investment in media for public awareness communication<br>• Investment in improvement teams | • Ability to reallocate health care spending to other determinants of health<br>• |

Includes what has been learned, as well as Changes and Design Concepts

- IT Implications
- Business Case Implications

## VI.Conclusions and Recommendations:

We have outlined a multi-step process in the engagement of regional sites in the Triple Aim. The details of this process are explained in the results section of this paper.

7. Initial contact
8. "Casing the Joint"
9. Boot camp for Triple Aim Principles
10. Community Asset Assessment
11. Purpose, Measures, Portfolio and Integration
12. Execution - pulling the trigger, forming workgroups
13. Development of a learning system

Triple Aim coalitions at the regional level are volunteer groups who are balancing the work on the Triple Aim with their full-time professional commitments. In order to move from a portfolio full of potential projects to executed work, leadership teams need to quickly identify people for whom this work makes sense in their normal day job. For instance, if a Triple Aim portfolio includes care coordination, the question is: *Who needs to be working on this as a significant part of their day job?* In this instance, a hospital association that is part of the Triple Aim coalition might be eager to support this work because of the constituency they represent and may even be able to provide individuals who can do actual work on this, or hospitals themselves might be very eager since there are forthcoming penalties related to readmissions. This action team can do the work and potentially raise more funds to support their project within the portfolio. The role of Triple Aim leadership is to provide direction, guidance and the development of action teams for the work .

Finally, we are now at the point where our effort and the organizations we work with need to be spent on execution of the portfolio. For the projects in the portfolio we need to go back to basics: What are we trying to accomplish; how will we know a change is an improvement; and what changes can we make that will result in improvement followed by running PDSA cycles? Adding to this, a developed scale-up plan in 5x steps (5 patients, 25 patients, 125 patients, ....) is needed. In parallel to this work, we need to develop the capacity of individuals to do this work and also make investment in infrastructure to support the portfolio. For the next year, our focused effort on with the Triple Aim regions will need to be put into execution of the portfolio.

## VII.Open Questions:

- ***How do we identify the people with improvement skills that will be needed to do this work in a region?***

## VIII.Appendices:

### Appendix A: The Value of Health in Health Care (Zoe Sifrim)

For communities pursuing the Triple Aim, simultaneously effecting change in health outcomes and health care brings to the fore the complex question of health care's role in creating health. During this 90-Day project, we have reviewed the literature for attempts to value health care's ultimate impact on health. Not surprisingly, there is considerable debate surrounding the methods and assumptions for valuing health care, and there is no consensus as to the definitive percentage of health outcomes that can be attributed to medical interventions.

Prior to beginning this investigation, we had often heard conventional wisdom that about 10% of health is determined by health care. However, the County Health Rankings team at the University of Wisconsin, traces this claim to a Department of Health and Human Services report from 1980, which sites "expert" estimates of the role of health care health care deficiencies in contributing to early deaths.[1] We did not uncover any recent research that confirmed the rumor of a value of 10% for health care.

Scholars who have attempted to value the impact of health care have tended to follow one of two basic lines of reasoning, according to an excellent review of this subject by Martin McKee.[2] First, some researchers have compared the change in mortality over time of conditions thought to be amenable to health care, versus the change in mortality of conditions not amenable to health care. In multiple studies, mortality declines since the 1950s have been shown to have been greater among conditions amenable to health care. For instance, Mackenbach used this method to calculate that from 1950 to 1984, conditions amenable to health care caused the population's life expectancy to increase by 2.9 years, whereas life expectancy would have otherwise declined by nearly a year.[3] The second line of reasoning, pioneered by John Bunker, approached the question from the side of the treatments, as opposed to the conditions. Bunker built inventories of treatment packages for certain conditions. Using the change in life expectancy for each condition and the theoretical change in life expectancy attributable to each therapy based on clinical trials, he estimated what percentage of life expectancy gains could be attributable to the therapies in practice. Using this method, Bunker estimated that about half of the increase in life expectancy increase since 1950 could be attribute to medical care.

Though Bunker's methods are compelling, his assumptions and conclusions have been widely critiqued as too optimistic.[2,4,5] Most prominently, Bunker does not account for the widely-recognized gap between the impact of therapies in the research setting versus in clinical practice.[4] He assumes, that is, that therapies have been implemented in routine practice just as they would be in the lab. Similarly, he is critiqued for underestimating the impact of inequalities on the effectiveness of clinical therapies at the population level.[5] Moreover, Bunker's methods are based on a specific set of medical conditions meeting particularly convenient criteria: those for which death rates had fallen, for which treatments had been shown to be effective in trials, and which were prevalent enough to impact life expectancy at the population level.[6] With these criteria, Bunker's findings cannot be said to be generalizable to all health care activities.
The shortfalls of Bunker's calculations highlight some of the many difficulties and confounding factors researchers face in determining the value of health care. Researchers struggle to accurately value interventions that improve quality of life but not life expectancy. Co-morbidities prevent an accurate attribution of the effects of treatment. Accounting for the negative effects of health care is exceedingly limited, due to lack of data and the invisible effects of underuse, overuse, and misuse.

Though the debate surrounding this issues thus does not coalesce around an agreed-upon percentage point estimate for the impact of care on health, medical care clearly has some measurable influence on health. Studies of the impact of a change in insurance status, for instance, point to health differentials based on access to care. A study of previously uninsured Medicare patients versus previously insured Medicare patients found that health differences between the two groups lingered for up to two years after enrolment in Medicare, but access to insurance was associated with the disappearance of the health differential after two years.[7] In a landmark RCT published by NBER during this 90-day wave, a randomized controlled trial compared Medicaid enrollees with uninsured patients and found a significant difference in utilization patters and self-reported health status.[8] Additional health outcomes data are to be published from this study in the future.

Ultimately, the value we ascribe to health care may be more subjective than objective. It will depend, for one, on the goals being pursued. For instance, if we are concerned with the life expectancy of the over-65 population, care may be deemed more influential than if the goal is to maximize life expectancy at birth. Likewise, if we are concerned with outcomes of acute or fatal conditions, care may be fare more valuable than if our goal is to maximize a population's quality of life over a lifetime. Thus, the value of care in a portfolio of health-related policies and program cannot be determined only by the assumptions of a researcher's model, but must ultimately be arrived at through a collaborative engagement of many stakeholders who set the aims and resource-allocations for a community.

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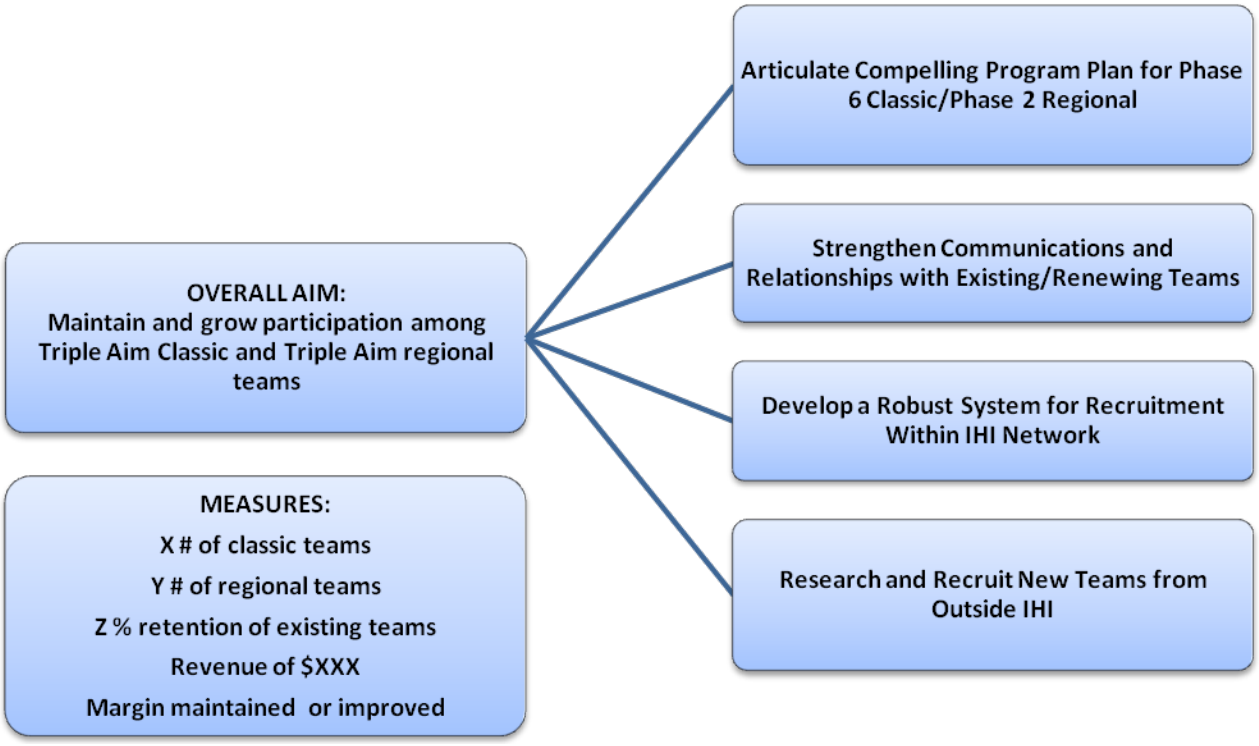
## Appendix B: IHI Triple Aim Recruitment Plan (Ninon Richartz and Martha Rome)

**IHI Triple Aim Recruitment Plan**
**Phase VI Triple Aim Classic Teams and Year Two Triple Aim Regional Teams**

**OVERALL AIM:** Maintain and grow participation among Triple Aim Classic and Triple Aim Regional teams

**Recruitment Goals:**

- **Primary Goal #1: Articulate Compelling Program Plan for Phase 6 Classic/Phase 2 Regional**
- **Primary Goal #2: Strengthen Communications and Relationships with Existing/Renewing Teams**
- **Primary Goal #3: Develop a Robust System for Recruitment Within IHI Network**
- **Primary Goal #4: Research and Recruit New Teams from Outside IHI**




| Primary Goal #1: Articulate Compelling Program Plan for Phase 6 Classic/Phase 2 Regional | |
|---|---|
| **Objectives:**<br>• **OBJECTIVE 1:** Determine Direction of Triple Aim Content in Next Phase of Work<br>• **OBJECTIVE 2:** Brainstorm and Decide Upon Activities, Sequencing, and Content Delivery Vehicles to Support Triple Aim Teams<br>• **OBJECTIVE 3:** Determine Goals for IHI's Learning System<br>• **OBJECTIVE 4:** Determine Adjustments to Measurement Strategy | **Strategies:**<br>• Discuss goals for team results<br>• Determine efficacy of growth (including implications for learning and revenue)<br>• Determine overall rationale and sequence of all Triple Aim portfolio programmatic activities and projects<br>• Determine response and strategy for teams unable to pay full amount for participation<br>• Brainstorm and Identify new additions to faculty base<br>• Discuss and decide upon UK-Based programmatic activities (and possibly write a UK-Based Prospectus)<br>• Update Phase VI Regional Prospectus<br>• Test Triple Aim Reflection, Navigation, and Assessment Tools |

**Tactics:**

- Hold brainstorming session with core team and core faculty regarding Phase VI activities, sequencing, and measurement strategies
- Discuss and revise Triple Aim navigation document to be more user-friendly
- Build and test tools for assessment of team progress
- Hold brainstorming session with core team and core UK faculty regarding UK-based activities

| Primary Goal #2: Strengthen Communications and Relationships with Existing/Renewing Teams | |
|---|---|
| **Objectives:**<br>• **OBJECTIVE 1:** Develop Recruitment Materials with Consistent Messaging<br>• **OBJECTIVE 2:** Determine Key Contact and Level of Readiness of Renewing Teams<br>• **OBJECTIVE 3:** Determine Level and Nature of Recruitment for UK-Based Triple Aim Teams | **Strategies:**<br>• Code level of readiness for current teams by engagement, decision-making power of key contact, etc. (Dormant/Low/Medium/High)<br>• Develop call/email strategy for enrollment, including standard email text |

**Tactics:**

- Scrub and code renewal list
- Discuss Phase VI activities on all-team communications (including all-site calls, workgroup calls, weekly newsletter); relate to renewals
- PM to develop work plan for renewals with timeline/deadlines
- Divide renewal list by team member to make one-to-one calls and emails regarding renewal (pull in faculty or higher level team members as necessary)
- Develop a set of "prospect days" devoted to contacting renewals/prospects

## Primary Goal #3: Develop a Robust System for Recruitment Within IHI Network

| Objectives: | Strategies: |
|---|---|
| • **OBJECTIVE 1:** Develop the Connection and Capacity of Executive Level Recruitment<br>• **OBJECTIVE 2:** Develop Recruitment Materials with Consistent Messaging<br>• **OBJECTIVE 3:** Develop the Connection and Capacity of Faculty Level Recruitment | • Update Phase VI Prospectus<br>• Prepare one page "issue brief" of latest thinking on the Triple Aim (including snapshot results from teams)<br>• Prepare slide deck of latest Triple Aim thinking for E-Team<br>• Understand Executive Level strategic contacts (calls, business development meetings, speaking engagements, site visits, industry meeting attendance) and build systems of follow up through executive team members, Exec Assistants, and TA Team members<br>• Understand Faculty Level strategic contacts (calls, speaking engagements, site visits, industry meeting attendance) and build systems of follow up |

**Tactics:**

- Recruitment Process Driver(s) reviews list monthly and reports on prospects at last weekly Team meeting (Thursday) of the month
- Meet with Executive Team to brief them on latest thinking around the TA, results from teams, and encourage leveraging contacts into recruited teams
- Follow up on leads within 24 hours of Executive Level-connection to prospect
- Recruitment Drivers attend Executive Assistant team meeting once a month to understand following month's travel schedules
- Five minute "Prospect Brainstorm" at monthly Faculty meeting to understand travels and conversations and potential TA sites

## Primary Goal #4: Research and Recruit New Teams from Outside IHI

| **Objectives:** | **Strategies:** |
|---|---|
| • **OBJECTIVE 1:** Develop Recruitment Materials with Consistent Messaging<br>• **OBJECTIVE 2:** Generate an Intentional Awareness Strategy for the TA tied to National Health Care Strategies and Initiatives<br>• **OBJECTIVE 3:** Develop A Robust List of Prospects from "Non-Traditional" or "Non-IHI" Spaces | • Update Phase VI Prospectus<br>• Promote Triple Aim participation at all outward-facing public programming<br>• Highlight results through IHI channels (website, WIHI, This Week @ IHI)<br>• Develop a public "issue brief" of Triple Aim framework's tie to national strategy<br>• Develop a monthly tracking system of all prospects, including determine level of probability of recruitment, with tiered strategy for each level<br>• Brainstorm, Research, and Develop a set of tactics for non-IHI traditional prospects (e.g., from within health care)<br>• Market at least one Triple Aim-related public program at all times |

**Tactics:**

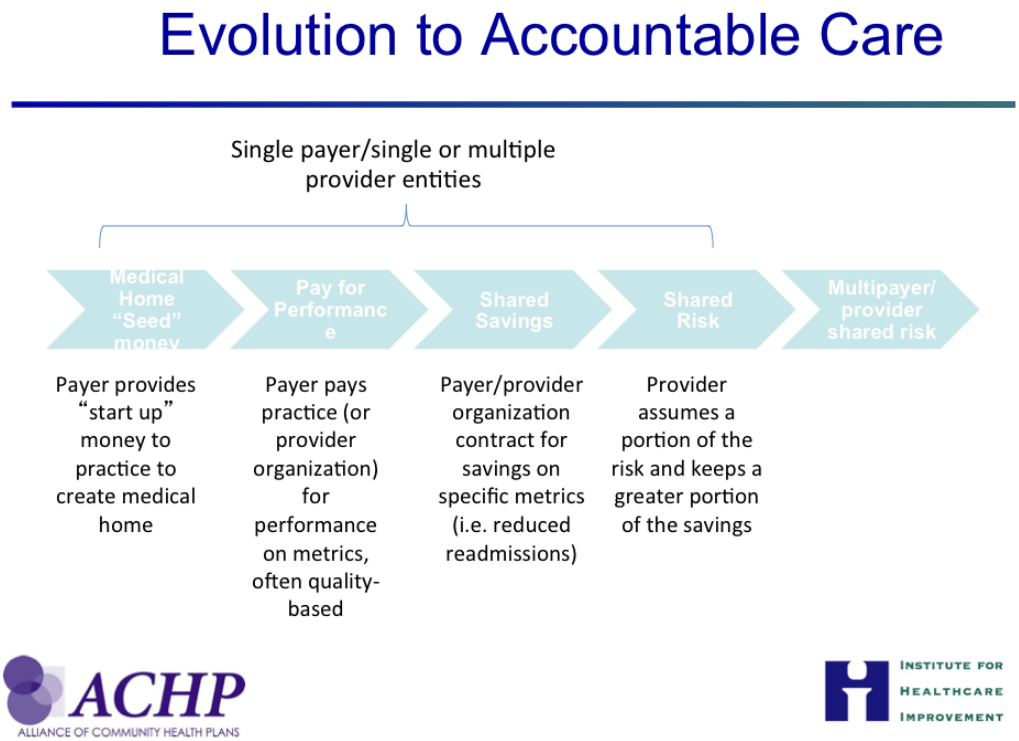
- Develop a robust contact list from past Triple Aims seminars, face to face meetings, old prospects (review quarterly)
- Develop and research a list of non-traditional or non-IHI Triple Aim prospects (employer groups, business coalitions, social services stakeholders, economic development, HIEs, etc.)
- Recruitment Process Driver(s) reviews list monthly and reports on prospects at last weekly Team meeting (Thursday) of the month
    - Determine Owner of prospect
    - Develop timeline goal for contact and appropriate contact medium (call, email, coordinate presence at a meeting, etc)
- Project Coordinator supports Recruitment driver in schedule calls per pipeline review
- Develop a set of "prospect days" devoted to contacting renewals/prospect
- Calls with organizations
    - Triple Aim is part of the organizations' mission
    - Senior Leader interest
    - Interest in working collaboratively
    - Experience with quality measurement
- Follow up email (this might be the place to track into Classic or Regional)
- Bi-yearly contact if still have medium to high probability
- Invite to face to face meeting if high probability and good fit
- Designated TA team member monitors Google alert for Triple Aim to identify any organizations using the Triple Aim as a strategy, or tie to national strategy
- Presence of TA team at national meetings
- Triple Aim Briefing/Informational Call two times per year
- Twice yearly Triple Aim public seminar
- Twice yearly Triple Aim Web&ACTION

## Appendix C: Controlling Health Care Cost

Cost curves are bent if there is an intention to bend them and a mechanism to act on the intention. Hoping that health promotion and better chronic disease management alone will "bend the cost curve" for a community is unrealistic. Rather than creating or aligning incentives among care providers and patients, eliminate disincentives for pursuing a common purpose. Move from a purpose that derives from payment mechanisms to a payment system that evolves from purpose and service offerings. Therefore if a region has the intent to control cost they need new mechanisms to control cost.

The Accountable Care Organization (ACO) is a recent experiment that is being used as a mechanism to control cost. Within the Triple Aim community we have conducted two sets of workgroup sessions during the past year. During this 90-day cycle we also had two conference calls with the organizations that are actively pursuing the ACO concept along with a face–to-face session at the Denver Triple Aim meeting in June.

The figure below describes some key learning from our first workgroup series. It sequentially outlines a series of payment models that can be used as mechanisms to control cost at a regional level. These are a set of potential tests that can be done for a community depending on where they are in their payment journey to manage the per capita cost for a community.



The above model also shows how Patient Centered Medical Home and other payments models are connected and may build on one another.

During the second set of workgroup calls for ACO we worked through the following six topics, and each participating organization shared where they were in this journey:

1. Aim/Goals
2. Organizational Structure
3. Data Infrastructure/Measurement
4. Attribution/Members/Population
5. Cost Control/Delivery Design
6. Payment Impact/Distribution

During this workgroup series the proposed CMS rules were released on March 31 for the ACO. The rules address many of the issues that were outlined above. They explained that for groups to share in savings, ACOs must meet quality standards in five key areas: patient/caregiver care experiences; care coordination; patient safety; preventive health; and at-risk population/frail elderly health. There are 65 measures within these areas. Lastly, they identified three aims that matched the Triple Aim and repeated these aims many times in the document.

Finally in the last series of ACO discussions as part of the workgroup, the following list of issues have surfaced:

1. Identifying the best bridging strategy to get from fee-for-service to population care. Are there any cost-effective ways to get there - rather than spending millions on start-up costs (e.g., using 3026, optimizing care transitions, as a vehicle)? One might think of this as a journey and ask, “What are the key milestones needed to reach along this journey?”

2. Establishing a total spend base line and trend for a specific population of patients.

3. Accountable Care Organizations and Community Empowerment.

4. How to restructure the billing process for providers and payers? How do we handle an episodic payment program for a chronic condition?

5. Identification of high risk, high cost patients within our total population of patients and how to begin to care for them in a different, more coordinated way. Predictive modeling tools and strategies.

6. Payer financial support to sustain the initiative for the long-term.

7. Balanced governance among stakeholders.

8. Integration of reporting capability across the delivery system.

9. Consumer engagement in design and governance.

10. Payment models for risk or shared savings agreements. How are the dollars divided between the different groups (hospital, physician, ancillary)? If we receive shared savings dollars or mange patients well and have money left, how is the money divided?

11. Using the ACO as a tool to drive competitive advantage in the market. Are others thinking this way and how would they do it?

12. Community-based care coordination team composition, management and support.

13. Useful attribution models/methodology for the Medicaid population.

14. Integrated delivery system partnering providers with health plans and moving patients to a Medicare advantage plan, example Everett Clinic.

This list of issues highlights the many challenges and opportunities that organizations face in creating an ACO.

In summary part of the work of this project was to make sense of out of the multiple initiatives that are going on within the US and how the Triple Aim interacts with them. Based on observations to date the Triple Aims themselves seem to be a strategic framework that many projects and organizations around the US are engaging with such as CMS, ACOs, Beacon Communities, individual health systems, even medical home initiatives, etc.

The next question is, *"How does IHI with its Triple Aim initiative interact with all of these initiatives?"* That is really a much harder question to answer. What we have seen so far is that an organization may be participating in multiple activities: ACO, medical home and IHI's Triple Aim community, at the same time. Maybe an easy way to connect this all together is that part of your portfolio of work for the Triple Aim is improved primary care and testing new payment models like the ACO.

## Appendix D: Regional Portfolio Development (Ninon Richartz and John Whittington)

| TA Dimensi | Target Populatio | Project Aims | Measures | Scope and Further |
|---|---|---|---|---|
| **MiHIA: "***Advance the reputation of our region as a place with demonstrated commitment to a community of health excellence* | | | | |
| | PH | **Building Developmental As among Adolescents Projec** (*Community Health & Regio Intelligence)*<br><br>**Project Description:** *Specific developmental assets and corr interventions affecting health will be identified through regre analysis.* | Short-term:<br>• Conduct Baseline Assessm Saginaw<br>• Identify and prioritize spec interventions determined regression analysis) to be would have the greatest ir health outcomes<br>• Identify and recruit people specific roles and responsi<br>• Collect process measures progress<br><br>Long-term:<br>• Administer follow-up asse measure outcomes | *No Measures Define* | **SCOPE:** Two County - Midlan Saginaw Students in 6th – 12t<br><br>• The concept of Develop Assets was developed b *Search Institute* in Minn This model consists of 4 character traits or attrib adolescent youth need successful. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | PH | **Together We Can Have Hea Children Project** (*Communi*<br><br>**Project Description:** *The Toge Can (TWC) Health Improvemer a six-county multi-partner coll sponsored by the Central Mich District Health Department (CI project partners with the Mich Health Institute and the regior educational school districts sto* | • The project will implemen Change Tool -School Secto utilized in 18 elementary s intermediate schools and schools. The results will be implement a policy change will result in school policie promote the health and e success of the students. | • Benchmarks used to determine progress v based on *A Guide to Measuring Advocacy Policy,* developed wit from the Annie E. Ca Foundation and will e change in the followi<br>• Social norms related value of health and a success of children a adolescents.<br>• The development of messages, common g resources assigned to to promote student h success.<br>• The number of comn members and organi who actively particip promoting health an success of students.<br>• The development an adoption of school p that promote the hea reduce health risks o students.<br>• Changes in the schoc environment such as spent in physical acti access to nutritious f | **SCOPE:** Central Michigan Hea Department 6 County Distric<br><br>Specific focus will be on addr<br>• Lack of access to nutriti schools<br>• Lack of education about including availability of foodstuffs,<br>• nutritional educational opportunities, and the i of physical activity<br>• Difficulty associated wit modifying the behaviors with unhealthy lifestyle lack of desire and/or ab change and institutional values. |
| | C | | **Advocate for improving effectiveness across all workgroup efforts** *(Payment/Cost Control)* | • Ensure cost effectiveness i being addressed in all wor Putting in place measurab performance elements tha results of health delivery improvement projects rela effectiveness. | • Ensure measurement elements in place to cost effectiveness for initiatives | |
| | C | | **Establish system of mea cost trends in the region** *(Payment/Cost Control)* | <u>Short Term</u><br>• Investigate best practices i communities including Wi Common Wealth Fund, GD the CHART Group and exa HRR Information.<br>• Investigate means of aggre multi-payor information to understand cost performa<br><u>Long Term:</u><br>• Have in place multi-payor<br>• Have in place reporting m health care cost performa region. | Total cost expended per p year:<br>• Adjusted for acuity, s and age/gender of p<br>• Adjusted for social ec issues as appropriate | |

| | | | | | |
|---|---|---|---|---|---|
| E | C | | **Health Delivery total cos improvement project: D Care** *(Payment/Cost Contr* | Short Term:<br>• Layout Learnings for best for community diabetic ca<br>• Gain stakeholder support implementing concept in r<br><br>Long Term:<br>• Implement diabetic care ir across full region. | • Reduce the total cost diabetic member.<br>• Improve compliance evidence based care continuum. |
| | C | | **Pursue Alternative paym models to reward the "r behavior" through paym** *(Payment/Cost Control)* | Short Term:<br>• Evaluate Mid-Michigan ini potential incentives for dis management.<br>• Review existing payor initi may provide reinforcemer diabetic cost of care impro project.<br>Long Term:<br>• Define payment models tc alignment of incentives to "right behavior" for chron management. | • As part of the Diabet Project evaluate plan for disease managem incentives. |
| E | | | **Establishment of a Patie Activation Measure** *(Longitudinal Experience of* | Create a Patient Activation Mea measures the patients overall c motivation, and determines wh are at in their overall health ex | *No Measures Definec* |
| E | C | | **Hospital Based Readmis Survey** *(Longitudinal Experience of* | Launch projects at three hospit examining:<br>• Current projects/teams/ef to reducing readmissions<br>• Begin data collection using readmission screening too cases at the three hospital | *No Measures Definec* |

| *TA Dimensi* | Target Populatic | Project Aims | Measures | Scope and Further |
|---|---|---|---|---|

**MEMPHIS, TN:** *"We will come together across our community to engage our constituents and leaders, align our resources, and coordinate c better population health, a better experience of care for patients, and lower per capita healthcare costs. We will achieve short and long-term meaningfully advance health equity, and increase the quality and joy of life for all of the people of Memphis and Shelby County."*

| | | | | | | |
|---|---|---|---|---|---|---|
| E | | | **Model End of Life Care P**<br>*(Longitudinal Experience of*<br><br>*Focus:*<br>• Care Transitions<br>• Focus on Education a<br>• Create a Model/Crea | Overarching Efforts<br>• Create and teach a sy<br>• Physician/provider ec<br>• Patient and family ed<br>• Faith-community eng education | *Measures Yet to Be D* | Rationale<br>• Lack of community stan standardized processes<br>• Fractured or non-existe<br>• Complexities of transitio off of care<br>• Lack of information abo palliative care resources use<br>• Silos of care – hospitalis specialists, palliative car<br>• Need for information tra<br>• Cost savings potential<br>• Improvement in hospita HCII that is high in Mem<br><br>Stakeholders/Key players<br>• Hospitals<br>• MQI<br>• ACOs<br>• Faith-community netwo<br>• Hospices<br>• Physician networks/orga<br>• Social worker/case man networks<br>• Social service organizati<br>• AFQ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E | | PH | **Management and Preve**<br>**Chronic Disease**<br>*(Longitudinal Experience of*<br>*Primary Care)*<br><br>***FIRST PROJECT:*** *Managing*<br>***SECOND PROJECT:*** *Preventi*<br><br>*Focus:*<br>• Improving Quality of through Relationshi<br>• Focus on Chronic Dis<br>• Redefine "primary" the healthcare provi | Overarching Efforts<br>Evaluate what is being done an working with:<br>• Commercially insurec<br>• Medicaid (TennCare)<br>• Uninsured | *Measures Yet to Be D* | Rationale:<br>• Include self, family friends, work, faith community, etc. in of primary care<br>• Document better o by strengthening a through relationshi<br>• Concept of Accoun or Primary Care *Co*<br>• Reduce health insu premiums<br>• Require mixture of access, system inn personal accountal practice-based and incentives, enhanc creative provider reimbursement<br><br>Stakeholders/Key player<br>• Memphis Business Health<br>• MCOs<br>• FQHCs<br>• Church Health Cen<br>• Congregational He Network and other community networ<br>• Memphis Medical<br>• Bluff City Medical S<br>• Social service orga<br>• Faith communities<br>• AFQ |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | PH | **Reducing Infant Mortalit**<br>**Pre - 0 to 3** *(Community H*<br><br>*Focus:*<br>• Healthy Start/Early L<br>• Focus on Pre-0 to 8 '<br>• Unite and Learn fror Current Efforts | Overarching Efforts<br>• Collect and learn fror efforts<br>• Develop a systemic a<br>• Reduce or coordinate | *Measures Yet to Be D* | Rationale:<br>• Unique challenge f Memphis; dismal h indicator<br>• Tied to social deter health<br>• Unplanned pregna counter economic sufficiency in wom of perpetuated pov<br>• Need for coordinat building on 41-enti infrastructure<br>• Differential cost of low birth weight/p birth<br>• Requires mixture o access, system inn personal accountab practice-based and incentives, enhanc creative provider reimbursement<br>• Alignment with exi poverty initiative<br><br>Stakeholders/Key players:<br>• Shelby County<br>• DHS<br>• MCOs<br>• FQHCs<br>• Early Success Coali<br>• Women's Foundati<br>• RISE<br>• Criminal Justice/Dc Violence |
| | | *TA Dimensi* | **Target Populatic** | **Project Aims** | **Measures** | **Scope and Further** |
| **WNC/ASHEVILLE, NC:**<br>**Purpose: "***Collaborate to enhance the well-being of Western North Carolina's population by improving the experience, value, a resources."* | | | | | | |
| | | E | **Reducing Falls Project**<br>*(Longitudinal Experience of Community Health)* | • Reducing falls for the ov population | • *Measures Yet to Be* | **SCOPE:** Five Counties - Hay, J Bunc, and McDowell |

| | | | | | | |
|---|---|---|---|---|---|---|
| E | C | | **Improving Care Transitio Project** *(Longitudinal Experience of* | • Improving care transitions 65 population | • *Measures Yet to Be D* | **SCOPE:** Three Counties - Rutl Polk, Henderson |
| E | C | | **Improving Advance Care Project** *(Longitudinal Experience of* | • Improving advance care pl the over 65 population | • *Measures Yet to Be D* | **SCOPE:** Western NC Region |
| | | PH | **Managing Adult Obesity** *(Longitudinal Experience of Community Health)* | • *Aims Yet to Be Defined* | • *Measures Yet to Be D* | **SCOPE:** One county initially - |
| | | PH | **Preventing Childhood Ol** *(Community Health)* | • *Aims Yet to Be Defined* | • *Measures Yet to Be D* | **SCOPE:** Western NC Region |

**Appendix E: Regional Tool Assessment** (Ninon Richartz and John Whittington)

During this phase of R and D work we tested or assessed 6 tools that we now have for helping regions.

1. *Sample Triple Aim in a Region Project Charter.* We are working with Memphis, Asheville and MIHIA regions to get them to produce charters for their workgroups. We should be able to decide in the next month if they will use the form and learn how helpful it was.

2. *Sample Regional Site Visit Agenda.* This tool will be modified. It was based on the agenda that we used at an earlier site meeting. Based on a later site we think we have improvements and will modify by the end of August.

3. *Site Visit Summary.* We used this tool after our visit to Memphis and found it helpful.

4. *Outline of a Model Portfolio.* This model was used in discussion with Memphis and it has been part of many Triple Aim presentations. More elements for cost control will be added to it.

5. *A Regional Approach to Measurement.* This tool has been shared with regions. Our measurement strategy is strong and it will be modified as needed. A new framework to think about these measures was introduced and it seemed to be well received at the June TA meeting.

6. *Site Evaluation Template*. This tool was written for ongoing evaluation of sites. After assessing this tool it needs to be redesigned and will be completed by the end of August