

# Triple Aim Approach

## Integrated Health Service Plan 2

### Appendix H



Ontario

Erie St. Clair Local Health  
Integration Network  
Réseau local d'intégration  
des services de santé  
d'Érié St. Clair



# Triple Aim Approach

## Appendix H

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## Triple Aim Framework

The Institute for Health Care Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

With rare exceptions, the IHI found that the United States health care system is disjointed, inefficient, and ineffective in promoting population health and in providing full value for the resources invested. This occurred 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. However, even in countries with highly integrated systems for delivering health care, there are still significant opportunities for improvement. These concerns are also reflected in the Canadian Health Care System.

In order to address the above issues, IHI advanced a new planning design intended to simultaneously accomplish three critical objectives, or what they call 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’s innovation team has taken the concept design further and described an initial set of components of a system that would fulfill or help to accomplish the Triple Aim. The five components are listed below:

### Focus on 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 coached 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

### 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

### 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

### 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
- 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

### System Integration and Execution

- 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

Starting in October 2007, IHI began working with a group of 15 organizations in the United States, England and Sweden, which are committed to implementing the five design components of the Triple Aim discussed above. In the summer of 2008 this group was expanded to over 40 organizations from the United States, Canada, England, Scotland, and Sweden. It was at this time that the Ontario Local Health Integration Network (LHIN) system took an interest in this approach and more recently, a provincial network of LHINs has agreed to consider this approach in their Integrated Health Service Plan 2 (IHSP2) submissions.

The IHI's *Triple Aim* Initiative aligns closely with the desired outcomes of the LHIN Integrated Health Service Plan 2, namely by transforming the health care system, focusing on three dimensions of care: 1) improving the health of the population, 2) enhancing the patient experience and 3) reducing, or at least controlling, the per capita cost of care. This approach also encourages its members to develop partnerships in their communities and involve other health care organizations, community groups, patients and their families in a co-ordinated effort to reach these goals. Finally, this framework provides the LHINs with a tool to evaluate its progress and success across a variety of areas relevant to the overall aims of the initiative (see table below for examples of specific measures).

**Table 1: Triple Aim Measures**

Dimension/Aim	Measure
<b>Population Health</b>	1. Health adjusted life expectancy (life expectancy and self-rated health status)
	2. Composite Health Risk Appraisal score
	3. Hospital and ED utilization for ambulatory care sensitive conditions
	4. Disease burden
<b>Per Capita Cost</b>	1. Cost per member of the population per month
	2. Hospital and ED utilization costs
<b>Patient Experience of Care</b>	<i>Ministry of Health and Long-Term Care (MOHLTC) Direction</i> - Improve access to emergency department care by reducing the amount of time that patients spend in the emergency department waiting
	<i>MOHLTC Direction</i> - Improve access to integrated diabetes care by supporting the roll-out of the current diabetes strategy
	<i>MOHLTC Direction</i> - Improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds
	1. Standard question focused on a patient’s overall experience
	2. Key question(s) from current patient survey