September 2012- August 2013

Executive Summary

The concept of better health, better health care, and lower per capita cost has become an emboldening principle for health system improvement around the world. The Institute for Healthcare Improvement (IHI), which pioneered the Triple Aim concept, invites you to join the **IHI Triple Aim Improvement Community** beginning in September 2012**.** Based on IHI's expertise in convening collaborative learning communities, activities will include:

- Guidance from expert faculty on setting up a robust Triple Aim strategy and portfolio of projects focused on a population.
- Key content such as models of care for key population segments; measurement strategies; testing, implementation and scale-up; asset-based strategies for community engagement and activation.
- A network for senior leaders to build strategic momentum and to ensure effective execution.
- Coaching to support simultaneous execution of multiple Triple Aim projects.
- Face-to-face learning sessions, WebEx calls, Extranet support.

This program will be lead by expert faculty who led the development of concepts, testing strategies, and measures for attaining the Triple Aim. Organizations that will benefit include:

- Integrated systems of health delivery and financing operating anywhere in the world.
- Integrated delivery systems considering ACO or other new payment models.
- Private or public employers seeking better health and value for employees.
- Safety net health care systems facing rising demands and flat budgets.
- Regional coalitions working to assure access for all while controlling costs.
- Public health departments or social agencies focused on populations with complex health issues.
- Primary care or multi-specialty physician groups.
- Private or publicly funded health plans committed to improving value.
- Organizations embarking on population-focused innovative designs.

Faculty are available for individual calls with interested organizations to discuss this opportunity and answer any questions. If you'd like to set up a conversation with one of our Triple Aim experts to talk about this opportunity, please contact Kathryn Brooks at kbrooks@IHI.org.

Design Concepts for Triple Aim Improvement

The Triple Aim Community uses a set of design concepts to organize the testing and change process: focus on the needs and capacities of individuals and families; primary care that encompasses a spectrum of supports to help people attain and maintain health; prevention and health promotion through multi-sector partnerships; per capita cost reduction to bring overall cost increases to a level not exceeding overall economic growth; and integration, social capital, and capacity building to allow independent stakeholders to align around the needs of the population.

Applying these change concepts successfully requires focusing on the following principles to catalyze concerted action.

1. **A clear purpose**, including what the team, coalition, or region/community is trying to accomplish and why.
2. **A cogent set of high level measures** that operationally define what a participating team or coalition means by health of a population, experience of care, and per capita cost.
3. An established **portfolio of projects and investments** to support the pursuit of the Triple Aim.
4. **A means of governing** and integrating the initiatives and investments.

Population Focus

The Triple Aim approach focuses on populations. Within the Community, we will address population scope in two ways:

Discrete populations are enterprise-level populations that make business sense. Typically, they are a group of individuals receiving care within a health system, or whose care is financed through a specific health plan or entity. Employees of an organization that is self-insured are one valuable illustration. In brief, the members of a discrete population can be known with some certainty.

Regional or community populations are inclusive population segments, defined geographically. People within a segment are unified by a common set of needs or issues, e.g. low-birthweight babies, or older adults with complex needs. However, they may receive care from a variety of systems, or may be unconnected to care. They may or may not be insured. It would be difficult to enumerate the population with certainty. When addressing regional populations, we recommend selecting segments where better health care can make a significant contribution to achieving Triple Aim results.

We expect that most participants will focus on discrete populations, though some (including many outside the US) will represent regionally defined systems or coalitions that have the capacity to address improvement on a regional scale. This Improvement Community is designed to assist all sites to learn and apply successful strategies for Triple Aim improvement in both types of populations.

Aims and Intended Results

The Triple Aim community is designed to help participating sites move toward improved results for their populations (discrete or regional) in three areas: health, care experience, and per capita cost.

Key milestones include:

- Selection of one or more populations (or segments) for focus, with a business and/or community rationale for addressing that population.
- 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.

Expected Results: While one year may not be enough time to produce dramatic changes in all three dimensions of the Triple Aim for a whole population or large segment, we intend that every site will successfully build a robust Triple Aim infrastructure for measurement and improvement, define and advance key projects within their portfolio to the level of measureable *project* results, and that some sites will attain measureable progress on all three dimensions of the Triple Aim, at least for pilot populations of strategic importance.

Priority Content

For all Triple Aim Community participants we recommend focusing on populations where health status has considerable room for improvement, where health care needs are fairly complex and present opportunities to reduce waste from the patient and system perspective, and where per capita costs are higher than average. For sites addressing regionally-defined populations, we recommend choosing issues where health care is a significant contributor to the solution allied with other social and behavioral determinants of health.

For Discrete Populations:

- Employee Populations: We believe a large number of health care organizations will get very high value from focusing on their employees. For health related organizations, focusing on employees as a population will strengthen their ability to apply similar approaches to other populations they serve.

- High Risk/High Cost Populations. The need for, and cost of, health care tends to be concentrated among small segments of the population. The elevated cost of care in these populations offer an opportunity to understand priorities and needs at an individual level, and to use these insights to craft designs of care that meet complex needs more effectively and at a significantly lower cost.

For Regional and Community Populations:

- Older Adults with Complex Needs. Older people, especially those with frailty, require a system of care that that allows them to live comfortably and meaningfully on their own terms without avoidable complications that are degrading and miserable. Example components of a better system of care include: negotiated plans of care, community based services focused on the home, optimal management of transitions, and contingency plans for illness and emergencies that minimize the need for hospitalization.

- Community-Wide Care for High-Cost, Medically and Socially-Complex Individuals. Multiple determinants of health need to be addressed in order to achieve innovative designs for high-cost, complex populations. Additionally, people with multiple health and social needs are high consumers of health care services; typically one percent of the population spends 25 percent of health care dollars.

- Community-Wide Governance and Activation Strategies. Community-level change requires effective coalitions and the ability to activate populations that do not currently interact with the health care system. Content will include: principles for coalition governance; engaging community-based organizations, businesses, unions, and stakeholders; community asset mapping and activation; and engaging community members in leading improvement.

System of Measurement

Each participant in the Improvement Community will develop a system of measures addressing outcomes at the population-level related to care, health, and cost. They will also develop project measures for each of the projects within their portfolio of Triple Aim work.

Population Measures: The selection of population-level measures will depend in part on the population chosen for focus. This process can start with exploration of what data are available, who has access, how often the data are summarized, etc. Once identified, participants will gather and display the data over time, integrating them into a system to support work on the Triple Aim. Example measures are shown below. See Appendix 1 for a more detailed list.

	Discrete Population Focus	***Regional Population Focus***
Health	▪ Health outcomes, disease burden, risk status for population members.	▪ Community wide measure of health, disease burden, or risk related to their chosen focus.
Care Experience	▪ Individual perception of experience; health system performance (e.g. IOM measures).	
Cost	▪ Per capita cost or a proxy measure such as inpatient or emergency department utilization or cost.	

Project Measures: In addition to population-level measures, sites will establish appropriate measures for each project in their portfolio. Project measures guide teams' learning throughout the process of testing and scale-up and provide a way to gauge progress in a shorter time frame than whole-population measures.

Learning Activities

The IHI Triple Aim Improvement Community is patterned on IHI's Breakthrough Series Collaborative Model[1]. Using an "all teach, all learn" philosophy, collaboratives include pre-work, team coaching, face-to-face meetings, and Web-based meetings where teams learn from expert faculty (see Appendix 2) and each other. These activities are shown schematically and are described below. Many community activities will be supportive of both discrete populations and community-wide populations, while others will target one or the other of these population types. Teams are welcome to participate in all learning activities, regardless of their population focus.

	Prework	9/12	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13	7/13	8/13
Getting started													
Building Infrastructure													
Learning Sessions			●					●				●	
Action Periods													
All Team Calls		●	●	●		●	●		●	●	●	●	●
Content Calls		●	●	●		●	●		●	●	●	●	●
Leadership Calls			●			●			●			●	
Harvesting													

- ***Getting Started :*** Prior to the September 1 start date, teams will complete a pre-work assignment, including a review of background literature, and an assessment of their organization's or coalition's readiness to engage in Triple Aim-related testing and implementation. They will gather intelligence on potential focus populations, project work currently underway, measures and data sources, partners and assets within their communities, and their team's current level of expertise in using improvement methods.

- ***Building and Enhancing Triple Aim Infrastructure:*** All teams will begin by completing a series of webinars focused on building the infrastructure to pursue the Triple Aim. Using web-based learning calls, the IHI faculty will introduce Triple Aim principles and coach teams through a sequence of key activities including: population selection; development of a cogent purpose, team formation; developing a measurement system and a portfolio of projects; and approaches to reducing costs. The

[1] http://www.ihi.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

infrastructure series will yield a specific plan for each site that will be the focus of their work for the remainder of the community.

- ***Learning Sessions:*** Teams will convene for one in-person and two virtual learning sessions. These meetings will provide an opportunity for learning, networking, and refinement of action plans. We strongly encourage the participation of 2-5 members of your team at all three meetings. For those who cannot attend the in-person meeting, there will be an option to participate virtually in selected sessions via WebEx. Teams will be asked to come to learning sessions with a summary of their Triple Aim work to date, usually in the form of a storyboard presentation.

- ***Action Periods:*** During the "action periods" between learning sessions, teams will use rapid cycle testing to advance their individual program plans. They will be expected to report monthly on their activities and measures, and to participate in the webinars described below, when appropriate. Action periods are devoted to testing new changes and to spreading those that have shown success. The intent is for participants to scale from smaller to larger populations as quickly as possible.

- ***Monthly All-Team Calls:*** One-hour, monthly WebEx sessions will take place with IHI faculty to explore general Triple Aim design concepts, topics in effective measurement, and examples of execution of system change. Teams addressing both types of populations (discrete and regional) are strongly encouraged to attend, as content will be relevant for all.

- ***Content Calls:*** Several times per month there will be a one-hour WebEx session with IHI faculty to explore specific Triple Aim content foci in greater depth. Content calls will be geared toward either discrete or the community populations. In each session at least one site will have the opportunity to present its work and receive active coaching and recommendations from faculty and the other sites.

- ***Leadership calls:*** Support at a leadership level is critical to the success of any Triple Aim endeavor. To that end, periodic calls will be dedicated to senior leaders of Triple Aim teams. Discussions will focus on strategic aspects of the Triple Aim, will-building, and governance issues.

- ***Harvesting:*** In August 2013, a virtual Harvesting session will be held in which results and learnings are shared and reviewed.

- ***Links to Other IHI Programming:*** As warranted, teams will be referred to additional IHI improvement training related to their content focus.

Site Characteristics

The IHI Triple Aim Improvement Community is designed to offer support and acceleration to participating sites with the following characteristics:

- Improvement in all dimensions of the Triple Aim is a strategic priority supported at the most senior (e.g. CEO and Trustee) level of the organization or coalition.

- Meaningful populations or population segments can be (or have been) identified for intensive improvement.
- Key partners are committed to participating. For instance, a health system is advised to include one or more health plan leaders in the project, and vice versa.
- Participating sites will designate a data analyst and other support sufficient to generate measures for all elements of the Triple Aim for the population(s) chosen for focus.
- Participants have good skills in executing improvement initiatives, and know how to set aims, carry out well-designed plan-do-study-act cycles, scale up successful tests rapidly.

Expectations of the Participating Sites

Senior Leadership Support: Because of the strategic and system-level focus of the Triple Aim, participating teams must have the explicit support of their senior leadership and these leaders must stay actively connected to the team's work. To maximize results, the IHI Triple Aim Improvment Community should be a recognized priority supported by each organization's senior governing board. The IHI team will convene the senior leaders periodically through a series of calls and dedicated time during learning sessions to discuss Triple Aim leadership and governance.

Dedicated Project Resources: The senior leader should appoint a high-level project leader to orchestrate overall participation and to drive progress on the site's Triple Aim project portfolio. For each project within the portfolio, a project leader with the time, resources, and accountability to succeed should be designated to oversee the day-to-day activities. Because of the challenges in securing population-level data, we strongly recommend designating a data expert to the team. A strong link between the organizational strategy and the Triple Aim should facilitate the fulfillment of this role.

Improvement Skills and a Record of Successful Improvement: To succeed in the Triple Aim requires that organizations have strong improvement capabilities at the individual project level and at the organizational, system, or population level. Suitable organizations 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. If additional skills are needed, IHI will recommend additional programming to help build the improvement capability.

Dedicated Support for Measurement and Data Infrastructure: Since few organizations or coalitions currently track all elements of the Triple Aim, most participants will need to develop new ways to collect and use data, including looking beyond their own data systems to external sources. Each participating team will identify a measurement lead to support the tracking of results over time. Throughout the Improvement Community, the IHI team will convene the measurement leads from each team via ongoing coaching calls to discuss common measurement challenges and approaches. Those responsible for oversight of the Triple Aim initiative should regularly monitor the measures. If improvement is not seen as project measures improve, it may be necessary to re-balance the portfolio of projects.

Partnering and Inclusion: Participating organizations will need to reach beyond their usual boundaries to develop multi-stakeholder partnerships. 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 organizations focused on improving the health of the community. IHI also expects participating sites to include patient, family, and community representatives as active team members.

Cost to participate

The cost to participate in the 12-month Triple Aim Community is $18,000 USD per site. In addition, organizations should be willing to dedicate staff resources, including time and travel expenses to participate in community activities. Teams are encouraged to enroll at least one month prior to the start date in order to allow time for pre-work.

To Enroll

If your system or coalition is interested in enrolling for the Triple Aim Improvement Community, please contact Kathryn Brooks (kbrooks@ihi.org).

To Learn More

A recording of a recent informational call led by Triple Aim faculty is available on our website.

Faculty are also available for individual calls with interested organizations. If you'd like to set up a conversation with one of our Triple Aim experts to talk about this opportunity, please contact Kathryn Brooks at kbrooks@ihi.org.

Appendix 1: Potential Triple Aim Population Outcome Measures

Dimension	Measure
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

Appendix 2: Core Faculty

The following faculty have guided the development of the Triple Aim since its inception. Additional content experts will be announced as the work begins.

John Whittington, MD, is the lead faculty for the IHI on the Triple Aim. He was formerly Medical Director of Knowledge Management/ Patient Safety Officer OSF Healthcare System. Prior to that position he worked for many years as a family physician. He has been involved as a faculty member on numerous IHI projects including: safety, spread, inpatient mortality reduction, the Executive Quality Academy and Engaging Physicians in a Shared Quality Agenda. He is part of the IHI team that works on research and development. He received his undergraduate degree and Medical degree from the University of Illinois. He did his residency in family practice at SFMC in Peoria Ill.

Kevin Nolan, MA, Statistician and Consultant, Associates in Process Improvement and Senior Fellow, Institute for Healthcare Improvement, has focused on developing methods and helping organizations, both within and outside of health care, accelerate their rate of improvement. He has served on the faculty of various IHI Breakthrough Series Collaborative Meetings, the Hospital Flow Innovation Community, the Operational and Clinical Improvement in the Emergency Department Community and large system spread projects. Kevin holds a Bachelor of Science degree in Mechanical Engineering from The Catholic University of America, a Master's degree in Measurement from the University of Maryland, and a Master's degree in Statistics, also from the University of Maryland. He is a co-author of the book *The Improvement Guide: A Practical Approach to Improving Organizational Performance*.

Carol Beasley, MPPM, Executive Director**,** develops and leads strategic projects for the Institute for Healthcare Improvement. Her projects have included health information systems in primary care, and the Triple Aim. She is trained in management, strategy, leadership, and organizational change and holds a Masters degree in Public and Private Management from Yale University.