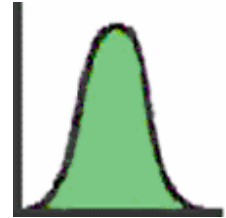


**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net

18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net



Summary of the Triple Aim Symposium
June 23-24 2008
National Harbor Maryland

The Triple Aim is the name Institute for Healthcare Improvement has given its initiative to address the key issues in healthcare in the United States, and possibly other countries, today. These are:

- Providing a good experience for the patient and family in their engagements with healthcare
- Improving the overall health of the population
- Reducing high per capita cost of healthcare

IHI points to key measures of these issues to demonstrate the failings of the current system, and then identifies the following Drivers of the current Low Value system:

High Cost	Low Quality
New Drugs and Technology not equal to outcomes No Mechanism to Control Cost at Population level	Over Reliance on Doctors Insignificant role for individuals and families
Supply Driven Demand	Under Valuing “System Design”

The improvement of these problem areas is the goal of all levels of care and health maintenance. Individual providers, health organizations including among others hospitals, health plans and governments and systems of care all can and should take on the effort and goal. Organizational goals should be aligned to achieve the triple aim. In order to embark on the initiative to achieve Triple Aim Results the effort should have a defined population. This target group should be able to be enumerated and per capita costs identified; it should be somewhat stable, large enough to be meaningful and generally not focused on a specific disease or condition. The implementation should begin with a modest sub-set of the overall population identified and increased over time.

Design of the Triple Aim

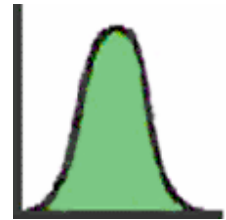
Each effort to address the Triple Aim must have a Macro-Integrator. This person or institution takes on the responsibility to pull together the resources to support a defined population, it builds alliances and coalitions to optimize the Triple Aim for a defined population; and it works with and helps micro-systems to support individuals. Some current examples of Macro-Integrators are available including such agencies and places as Bellin Health, Cincinnati Children’s Hospital, Care Oregon, Vermont State Blueprint for health and Queens Health Network (NY)

**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net

18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net



The care design for achieving the Triple Aim:

- focuses on the needs and accommodation of the individual and the family;
- redesigns primary care services to assure access to coordinated care;
- develops a system of care to address population health management including among other things customizing services, using predictive models, working with the community to encourage healthy behaviors, and setting and executing initiatives to reduce inequitable variation in outcomes or practices;
- controls costs by reducing inflation rates to 1 to 3% per capita through eliminating overuse of specialists, breaking or countering incentives for supply driven care; and reward health care providers for contributions to producing better health, not just more care;
- develops system integration by:
 1. matching capacity to demand and social services;
 2. ensuring strategic planning is informed by the needs of the population; and
 3. developing a system of ongoing learning and improvement.

Redesign of Primary Care

The redesign of primary care has to be developed with the five basic goals of the Triple Aim in mind. Control of the process needs to reside with the patient and family regardless of the severity of the problem. The team should be able to cover at least 70% of all necessary services, but with ready cooperation with other specialties and services. Medical care usually focuses on a specific diagnosis which it then attempts to treat. However, in many cases the root cause of the person's need for service is in some other aspect of the person's condition. In order to reduce medical costs it may be, and often is, necessary to involve support from non-general medical services. Case managers, behavioral and social services providers are all called for in a redesigned system. The new system must avoid duplication of service and assure parallel work flow to avoid bottlenecks and extra cost or long delays. Educating all staff to the underlying assumptions and values is very important to success in the redesign. There is only enough funding for one model, and that means we have to stop doing things which conflict with the basic approach.

Examples of the redesign of the system might be South Central Foundation of Alaska Native Medical Center and Genesys Health System. A key strategy is use of case managers. These systems focus on health not illness, promote the continuous healing relationship, integrate a coordinated network of care, and work through community partnerships on a shared vision.

Individual and Family Centered Care

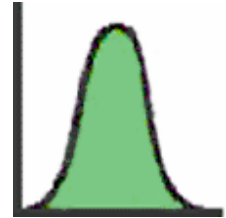
To achieve the objectives of the Triple Aim the system of care has to be individual and family

**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net

18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net



centered. This means care has to be provided in a broader context. Care has to take into account the broader social context of the person's life. Healthcare providers don't have to solve the problems of chronic disease alone, there are many other effective programs which can be accessed as joint supports. Patients can take some responsibility for their behavior. Providers must reach out to these other types of services to assure adequate supports for many people, especially those with chronic diseases. These have to include supports such as housing, aging programs and other charitable and social agencies or services. Efforts to improve exercise levels, support smoking and drinking cessation and establish social activities to increase wellness are all a part of this person/family centered approach.

The System for Improvement - Toward Reaching the Triple Aim

In developing a systems approach to achieving the Triple Aim, an organization needs several attributes. These include:

- A level of ambition and consistency with organizational priorities
- Methods to form coalitions
- System level measures to define the aim for a given population
- Themes or segments for guiding system changes
- Prototype testing beginning with the individual and family
- Scale-up and spread
- Anchoring the new approach in the community

In developing the implementation and the scale up, a useful model is the 5X scale, or increasing the number of people or level of expansion by five times the previous number for each new iteration. Selecting skilled leaders is important to the implementation of these projects.

Incorporating Public Health Management and Community Interventions

In order to achieve the connection of care needed to achieve the Triple Aim it is important, even necessary, to:

- Customize Services by segmenting the population based on health risk
- Use predictive modeling which takes into account situational factors
- Work with the community to advocate for circumstances and factors to promote health behaviors
- Reduce variation in inequitable outcomes or undesirable variation in practice.

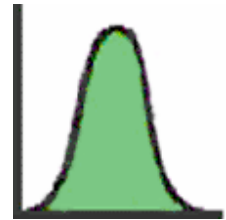
Use of health risk assessment tools will make it possible to obtain crucial patient data and prioritize care. Predictive modeling will help tailor interventions and use of resources, and reduce waste. If it is used or applied on first encounter, the consumer can be identified in relation to intensive services and case management requirements. Working with the community

**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net

18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net



allows the spread of messages and services to people where they spend most of their time. Most care happens within the cultural and other values of the person and the society, and it changed one person and one decision at a time. It is important to include in this process efforts to reduce variation. Reducing variation has to begin with evidence based practice and guidelines, and should include quality improvement efforts, engage community stakeholders and begin with an issue most important based on data showing the greatest opportunity.

In the pursuit of better incorporation of services into wellness, it is important to build community collaborations. These usually have to be constructed one connection at a time. There are several tools available to help organize thinking about these collaborations, and they can provide a framework and approaches to develop these new structures.

The Macro-Integrator

In order to have a new collaborative model patient/consumer centered system of care including community and health system resources, a key ingredient is the “Macro-Integrator.” This organization may be old or new, and may have any of a number of different basic roles. In every case it pulls together the resources to support a defined population, it builds alliances and coalitions, it optimizes the Triple Aim and it works with and helps to improve micro-systems to support individuals.

The Integrator has a number of key functions:

- Design and implement patient centered care models and engage the population
- Design and implement integration of health, public health and supporting social services
- Design and implement new financial models
- Establish accountability and governance structures
- Design, implement and improve performance measures
- Develop and deploy information technology to support care and assess performance

These organizations may be vertically integrated such as Kaiser or Health Partners, or horizontal such as CareOregon, where there is no ownership but a common agreement and a trust and learning network. It might also be a hybrid of these two models, or it might even be a “trans-enterprise unifier” such as Bolton Primary care Trust in the UK or Jonköping County in Sweden.

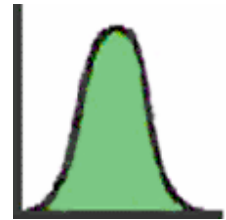
Integrators are recognized as local leaders in healthcare: they work collaboratively with partners, seek to engage the public and especially consumers to shape services, engage clinicians to drive quality and engagement, undertake regular needs assessments and prioritize investments according to local needs. The medical home is a form of integrator, but it can be effective or

**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net

18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net



ineffective depending on the organizational approach and expectations of the people managing it. The medical home requires a wide variety of supports to be truly effective in improving health, but it can be a starting point for redesign. The integrator can be a community level organization or a state organization. Community level integrators will need payment reform, community care coordination, community based public health efforts and cost control at the community level. State level support is important for successful integration for executive management and support, blueprint development, financial reform and health information technology.

Controlling costs

Controlling costs is a key component of the Triple Aim. The prime objectives in this area are:

- Achieve 1-3% inflation in per capital costs per year – by developing strong relationships with a group of specialists committed to reducing overuse and focus on care coordination
- Achieve the lowest decile performance in the Dartmouth Atlas measures – by breaking or countering incentives for supply driven care
- Reward providers of all types for their contribution to producing better health not just more services

There are both demand and supply side methods for controlling costs. On the demand side it is possible to change individual behavior to both demand and require less formal care; and to encourage suppliers not to try to increase demand, especially to compensate for other losses. On the supply side, there can be financial incentives to suppliers not to over produce, but rather to produce the right product. This means paying for health, not health care. As an example there is an index of hospital intensity, based on time spent in the hospital, intensity of physician services and use of care by chronically ill patients. Those with the greatest supply have the highest use with no improvement in health.

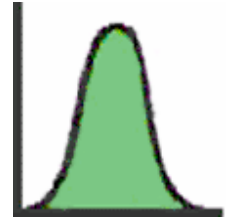
QuadMed, which serves the Quad/Graphics Company, has developed a good beginning model in controlling costs. They provide on site primary and selected specialty care; focus on prevention and wellness; have restructured delivery to use salaried providers, incentives for quality and satisfaction with ample “face time;” use narrow network contracting for specialty care; remove waste; and integrate workers compensation services into the primary care system. These changes have held their use of care per employee to about 70% of the industry norm. Other models are certainly possible. They must:

- Have a long term focus on improving health
- Have a long term focus on quality improvement
- Have a strong organization team
- Work with employers on benefit design, use of health risk assessments, health

**The Institute for
Behavioral Healthcare
Improvement
(IBHcI)**

“Improving the Performance Curve in Behavioral Healthcare”

112 Maplewood Drive
Scotia, New York 12302
Phone/fax: (518) 394-1700
Email: aldenjoe@att.net



18 Clove Road
Castleton, New York 12033
Phone: (518) 732-7178
Email: Brownpcmd@att.net

- coaching and strong access to care
- Work with a relatively narrow specialist group.

Prime methods for controlling costs might be better patient training, creation of primary care teams and assuring all consumers/patients are cared for by a team, joint planning between the consumer and care team, assurance of adequate social supports and selecting hospitals with lower HCL.

The Triple Aim will be successful to the extent potential Mega-Integrators recognize and adopt these goals and methods. No one organization can be successful alone, but both IHI and IBHI can provide significant vision and support for its implementation.

Peter C. Brown
July 2, 2008