INSTITUTE FOR HEALTHCARE IMPROVEMENT

TECHNICAL BRIEF

Best Health Care Results for Populations (A Three-Part Aim)

Achieving the optimal balance of good health, positive patient experience of care, and low per capita cost for a population

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Intent: (1) Describe the "Best Health Care Results for Populations" initiative; (2) Outline the challenges to achieving results; and (3) Propose an approach to developing solutions.

Background: "Once upon a time, it was taken as an article of faith among most Americans that the U.S. health care system was simply the best in the world. Yet growing evidence indicates the system falls short given the high level of resources committed to health care. Although national health spending is significantly higher than the average rate of other industrialized countries, the U.S. is the only industrialized country that fails to guarantee universal health insurance and coverage is deteriorating, leaving millions without affordable access to preventive and essential health care. Quality of care is highly variable and delivered by a system that is too often poorly coordinated, driving up costs, and putting patients at risk. With rising costs straining family, business, and public budgets, access deteriorating and variable quality, improving health care performance is a matter of national urgency."(1)

When the United States is compared to other countries on major markers of health, we rank 31 on life expectancy, 36 on infant mortality, 28 on male healthy life expectancy, 29 on female healthy life expectancy, and 1 on health care expenditure.(2)

"Health care systems have evolved around the concept of infectious disease, and they perform best when addressing patients' episodic and urgent concerns. However, the acute care paradigm is no longer adequate for the changing health problems in today's world. Both high- and low-income countries spend billions of dollars on unnecessary hospital admissions, expensive technologies, and the collection of useless clinical information. As long as the acute care model dominates health care systems, health care expenditures will continue to escalate, but improvements in populations' health status will not."(3)

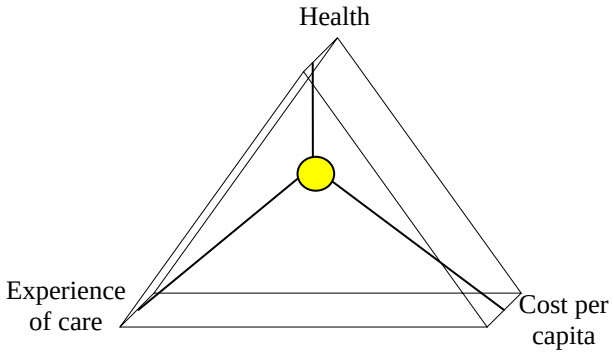
Looking at one measure of how well a system works, such as infant mortality, a clear range of values is noted in the U.S., from a low rate of 4.4 per 1000 in Vermont to 11.3 per 1000 for the District of Columbia.(4)

The Institute for Healthcare Improvement (IHI) is a leading force driving change in health care in the U.S. Our mission is to help design, discover, document, and spread innovations in health care delivery that achieve the Institute of Medicine's "Six Aims for Improvement" (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity) better than any existing designs. IHI's founders, Board of Directors, staff, and faculty are confident that such redesign is possible and can significantly reduce the per

capita cost of U.S. health care, while also improving both the health of a population and the experience of care.

Current Landscape:
Transformation of health care delivery starts with a transformational aim. IHI believes that one such transformational aim includes a balance or optimization of performance on three dimensions of care—which IHI calls the "triple aim":

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.



These three dimensions of care pull on the health care system from different directions. Changing any one of the three has consequences for the results of the other two, either in the same or opposite directions. For example, improving health can raise costs; reducing costs can create poor outcomes, poor experience of care, or both; patients' experience of care can improve without improving health. With the goal of optimizing performance on all three dimensions of care, we recognize the dynamics of each dimension while seeking the intersection of best performance on all three.

The Problem: Achieving this triple aim is a significant challenge, partly because it is not entirely congruent with current business models of US health care organizations. For example:

- Hospitals seek to improve the quality and experience of the services they provide for their patients, but they are less concerned with the care of a defined *population* of patients. Furthermore, it is frequently not in hospitals' best financial interest to reduce costs per capita, as such cost reductions would require significant reductions in high-cost services like hospitalizations and high-technology procedures, which are the financial lifeblood of hospitals.

- Physicians and medical groups are interested in the quality of the services they provide, but are rarely responsible for a population of patients. Moreover, the incentives to reduce per capita costs are absent in a fee-for-service system.

- Payers seek to reduce per capita costs for the people they cover, but their leverage to improve health care and patient experience is low.

Our present system of health care is fragmented, with little coordination of care among parts of the system. Although we have seen improvement in discrete components of health care, there has been minimal improvement in the system as a whole. The recent *Dartmouth Atlas* work reveals waste in resources for care at the end of life, but the financial incentives are misaligned to produce change. Per capita US health care costs continue to rise, spurred by increasing use of technology as well as increasing prevalence of various medical conditions.(5)

As we consider the redesign of the health care system, we face key challenges:

- Producers control demand.
- New technologies are expensive and have a limited impact on outcomes.
- The current system relies on a physician-centric model of health care.
- There is no foreign competition to spur change (cf. Toyota and the auto industry).
- There is little appreciation or use of system knowledge.

Developing Solutions:

To achieve the triple aim, an organization must act as *an integrator*. The best examples of this occur in fully integrated health care systems, where one entity is responsible for health, experience, and costs per capita for a population. These organizations have the best chance for transformational change. Such is the case with two of IHI's current Strategic Partners, Kaiser Permanente and Jönköping County, which have fully integrated financing and delivery structures and use these structures and methods to good advantage.

Although full integration is the most direct approach to achieving this transformational aim, such arrangements will affect only a fraction of the US population—i.e., those currently served by the fully integrated systems. IHI firmly believes that organizations must find other models to successfully execute the integrator role and drive coordinated improvement to achieve optimal performance in population health, experience, and cost. Moreover, integrating to achieve the triple aim does not necessarily require that all parts of the system that provide care to a population must reside within a single organization. For example, integrators could include the following:

- A powerful, visionary insurer, with a sense of the needs of the communities it serves;
- A large primary care group that establishes the appropriate partnerships with payers; or
- A hospital, offering services through its Physician Hospital Organization, that performs well on all three dimensions and therefore attracts payers.

Regardless of which organizations partner to be the integrator, we hypothesize that the most successful models will link health care organizations across the spectrum of care. The service models will be based on patient needs and preferences, and population needs to optimize health and reduce waste in the system. Further, we believe that this important function of linking organizations requires a single organization that integrates other health care service "suppliers" into a system that works for a defined population.

Aim of This Initiative:
IHI seeks to explore and develop a variety of models, to identify different ways of achieving transformational results that balance the best possible performance in health, patient experience, and per capita costs of care. More specifically, we seek to identify systems in the US that achieve the top deciles on measures of patient experience, health of a population, per capita cost, and controlled inflation in costs to <3% per year.

Models capable of achieving this level of performance will need to address the following issues:

Role of Integrators:

1. What are the key tasks for integrators?
   - Design care models, financial models, and approaches to engaging the population to reach the three-part aim.
   - Establish essential business relationships.
   - Measure performance in new ways.
   - Test and analyze effects of this approach, continually learning what works to reach the goals.
   - Develop and deploy information technology for use by patients and suppliers.
2. What is needed to develop a strong partnership that supports a payer and a provider as integrators?
3. In a non-integrated care delivery system, what leverage does the integrator need to be successful and how is this leverage acquired (e.g., market share, ownership agreements, cooperative agreements, etc.)?
4. Can a group of highly activated patients who are aided by information technology act as integrators of their own care? Achieving this will be an important innovation for a segment of the population. However, the percentage of patients capable of this degree of activation is currently small and will contribute minimally to transformational change in the short term.

Measurement:

1. What are the best measures to track progress? The Whole System Measures developed by IHI (see www.IHI.org for more information) have proven to be a useful way to evaluate performance of a large system. Will the Whole System Measures suffice for measuring progress toward achieving the transformational aim, or do we need other types of measures?

2. Data on costs and some outcome measures are relatively easy to capture, while experience can be much more difficult to measure. How can we track experience of care from the population and the patient perspective?

3. What are the processes for monitoring performance (including setting common goals), sharing the burden of measurement, and supporting technology for information sharing and measurement?

4. What is the best way to manage discussions about establishing targets and achieving goals? What if targets are not met?

Relationships with Suppliers

1. Suppliers to the care system—hospitals, specialty and primary care groups, home health agencies, and nursing homes—must understand how they stand to benefit if they are to change their services to reach the stated goals. How can systems establish win-win arrangements, financial and otherwise, to make the system work?

2. Agreements about specific aspects of care, including timeliness, safety, and use of evidence-based care, will be the infrastructure for relationships within the care system. What types of agreements work best to ensure the alignment of goals and care?

Next Steps: IHI is seeking a small group of forward-thinking organizations to actively participate in this work to explore and test models for achieving the three-part aim, and to execute the integrator role and work with suppliers to achieve unprecedented results for both the population and the organization.

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