

# The Triple Aim

## A framework for achieving value

The NHSScotland Route Map to the 2020 Vision for Health and Social Care describes 12 priority areas for action. These areas identify action for high quality sustainable health and social care services in Scotland in each of the three Triple Aim domains.

### What is the Triple Aim?

The Triple Aim is a framework that describes an approach to optimising health system performance through the simultaneous pursuit of three dimensions:

- improving the quality of healthcare
- improving the health of the population, and
- achieving value and financial sustainability.

It highlights the importance of working on all three components in parallel and recognises the interconnections; a change in one component can affect the other two, either positively or negatively.

The Institute for Healthcare Improvement (IHI) developed the Triple Aim framework and tested the prototype in more than 100 organisations across the world in settings that varied from integrated health systems to social service entities and regional coalitions.

### Why is the Triple Aim important?

Changing population demographics and increasing chronic ill health are putting new and increasing demands on health and social services at a time when public sector finances are under increasing pressure. This means that greater value is being demanded from the resources allocated to healthcare systems.

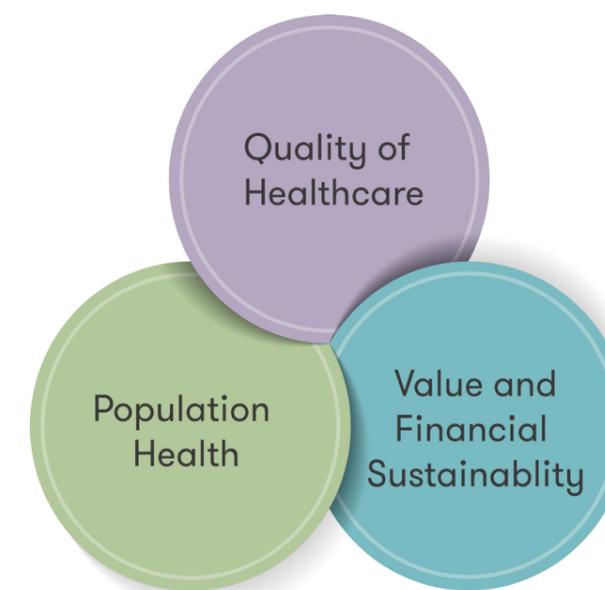
### How to deliver the Triple Aim?

Based on six phases of pilot testing with over 100 organisations around the world, IHI recommends a change process that includes: identification of target populations; definition of system aims and

measures; development of a portfolio of project work that is sufficiently strong to move system-level results; and rapid testing and scale up that is adapted to local needs and conditions.

Through the pilot testing, it has been found that to do this work effectively, it is important to harness a range of community determinants of health, empower individuals and families; to substantially broaden the role and impact of primary care and other community based services; and to assure a seamless journey through the whole system of care throughout a person's life.

Therefore, the key to delivering the Triple Aim is the establishment of a system integrator whose role is to coordinate and direct the resources allocated to a population group with the aim of optimising performance against the three aims. The fact that Scottish health boards are responsible for health care planning and delivery across the totality of their population, combined with the health and social care integration agenda, means that Scotland is in a strong position to deliver improvements against the Triple Aim.



## References & resources

1 Stiefel M and Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. Institute for Healthcare Improvement, 2012.

© NHSScotland Quality Improvement Hub 2014

# Local and international examples of using the Triple Aim to achieve value

## Empowering service users with dementia and their families in Midlothian

Family Group Conferencing (FGC) is designed to empower families and people with dementia to develop their own solutions to planning care and support, with support as required from professional services. The approach puts families at the centre of the decision making process enabling them to feel empowered and have ownership of the plan. It also engages the wider family network where previously the caring may have fallen predominantly to one or two key members of the family. Midlothian Council piloted the FGC for people in varying stages of dementia and their families in 2012-13.

- AIMS:**
- Reduce and/or delay the need for formalised services
  - Enhance the provision of co-ordinated care and support within the family network

**Intervention:** FGC coordinators meet with family members and the person with dementia individually, before convening a meeting with all to develop a care plan.

**Examples of outcomes:**

- Population health*
- ▲ living well with demetia for longer in their own home
  - ▼ burden of caring and the associated negative health and wellbeing implications
- Quality of healthcare*
- ▲ empowerment of individuals and their families to make the best possible decisions
  - ▲ views/wishes of person with dementia being heard and taken into account
- ▲ provision of targeted professional support/ services
  - ▲ partnership between families and professionals
  - ▲ engagement of family network beyond primary carer
- Value and financial sustainability*
- ▼ cost compared to package of care that would have been put into place without FGC

## The Triple Aim at a system level in Counties Manukau District Health Board, NZ

Counties Manukau District Health Board (CMDHB) is responsible for the funding of health and disability services and for the provision of hospital and related services for the people of Counties Manukau. It is one of New Zealand's largest DHBs and the region is the most multicultural and fast-growing communities in the country.

CMDHB has developed a system-wide portfolio of work to enable them to achieve their strategic objectives in alignment with their commitment to the Triple Aim [see: <http://www.countiesmanukau.health.nz/achievingbalance/Strategic-Programme-Management-Office/Attachments/SPMO-Driver-Diagram.pdf>]. Some examples of elements of the CMDHB 'Achieving a Balance' Driving Diagram are outlined below:

Triple Aim	Strategy	Deliverable	Components	Benefits
Improved health and equity for all populations	Better Health Outcomes for All	Smokefree CMDHB by 2025	Improving reach and efficacy of Smoking Cessation support	Reduced prevalence of smoking to 12% by 2018 and to 5% by 2025
Improved quality, safety and experience of care	First Do No Harm	National Patient Safety Campaign	Development of baseline and on-going measures	Reduced health-care-related harm
Best value for public health system resources	System Integration	A Risk Individuals	Locality clinical partnership and clinical pathways	Ensuring equity of services across locality areas

## Chronic disease prevention and management in the Hamilton Niagara Haldimand and Brant Local Health Integration Network, Canada

The Local Health Integration Network (LHIN) plans, funds, and integrates health care. Chronic conditions are the leading causes of illness, disability and poor quality of life, and can cause great burden for individuals, the workforce, the health system and communities. More than one million LHIN residents report one or more chronic condition.

- AIMS:**
- Reduce by 20% the number of A&E visits and hospitalisations among vulnerable populations by 2012
  - Decrease by 2% the obesity rate in Fort Erie by 2015

- Interventions:**
- Self-management education for individuals and providers
  - Evidence-based lifestyle program, 'Healthy You'
  - Case management approach to improve access to community services for frequent visitors of A&E units

**Examples of outcomes:**

- Population health*
- ▼ smoking, obesity, physical inactivity, unhealthy eating
  - ▲ uptake of screening, vaccinations, infection prevention
- Quality of healthcare*
- ▼ unplanned return visits to the A&E
- ▼ people hospitalised when could be cared for elsewhere
- Value and financial sustainability*
- ▼ A&E visits by people with chronic diseases hospitalisations of people with chronic diseases

## Youth Mental Health, ImpactBC, Canada

Initially focusing on a single sub-population of students of Killarney secondary school in eastern British Columbia, the overall objective of this work is to close the gaps in mental health service and outcomes for youth in British Columbia.

- AIM:**
- Increase diagnosis, screening and treatment for anxiety and depression among ages 12-18 in 2 years

- Interventions:**
- Mobile mental health crisis unit
  - Youth mental health module for Primary Care providers
  - Primary Care providers have regular hours at schools

**Examples of outcomes:**

- Population health*
- ▼ suicide attempts/violent incidents
  - ▲ graduation rate
- Quality of healthcare*
- ▲ youth participation in care decision
  - ▲ primary care confidence using diagnostic tools
- Value and financial sustainability*
- ▼ youth mental health related A&E visits/hospitalisation
  - ▼ number of calls to police from Killarney High School