

# The Triple Aim: What Healthcare Reform Means for the Board Quality Committee

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**I**N RECENT YEARS, MANY HOSPITAL and health system board quality committees have taken their cues on what to measure and improve from Medicare—generally their largest single-payer—and The Joint Commission, as well as from private insurer and employer initiatives such as The Leapfrog Group. Thus, board quality committees look mainly at inpatient hospital care, for example, reviewing dashboards with externally established quality indicators such as surgical site infections and ventilator-associated pneumonias. Even the government mandated patient satisfaction surveys (Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS) are for inpatient care only.

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However, the landscape is changing. A number of elements of the Patient Protection and Affordable Care Act (PPACA) as well as private payer initiatives suggest that board quality committees should rethink their work to reflect the imperatives and incentives of the legislation. Provisions concerning accountable care organizations (ACOs), value-based purchasing, bundled payments, and patient-focused medical homes are intended to encourage healthcare providers to take accountability across the care continuum, from preventive and physicians' office care to outpatient centers, inpatient care, and rehabilitation. Providers will be held accountable to measure and manage not only hospital quality and safety, but also the total costs and outcomes of healthcare no matter where patients are treated.

## Triple Aim

The new Medicare chief, Dr. Donald Berwick, announced that the so-called "Triple Aim" will be a centerpiece of his agency's efforts to



reform healthcare and control spending.<sup>1</sup> The Institute for Healthcare Improvement (IHI), which Berwick founded and ran until this year, launched the Triple Aim initiative in October 2007. The three components of the Triple Aim are to:

1. Improve patient care according to the six aims enunciated by the Institute of Medicine (i.e., that care is safe, effective, patient-centered, timely, efficient, and equitable).
2. Improve the health of patient populations and communities.
3. Lower the per capita costs of healthcare.

A recent article from The Commonwealth Fund explained the significance of the Triple Aim: "Pursuing these three objectives at once allows healthcare organizations to identify and fix problems such as poor coordination of care and overuse of medical services. It also helps them focus attention on and redirect resources to activities that have the greatest impact on health. Without balanced attention to these three overarching aims, healthcare organizations may increase quality at the expense of cost, or vice versa. Alternatively, they may decrease cost while creating a dissatisfying experience for patients."<sup>2</sup>

- 1 "Berwick Brings the 'Triple Aim' To CMS," *Health Affairs* blog, September 14, 2010, accessed at [healthaffairs.org/blog/2010/09/14/berwick-brings-the-triple-aim-to-cms/print](http://healthaffairs.org/blog/2010/09/14/berwick-brings-the-triple-aim-to-cms/print).
- 2 Douglas McCarthy and Sarah Klein, Issues Research, Inc., "The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs," published by The Commonwealth Fund, available at [www.commonwealthfund.org/Content/Innovations/Case-Studies/2010/Jul/The-Triple-Aim-Journey.aspx](http://www.commonwealthfund.org/Content/Innovations/Case-Studies/2010/Jul/The-Triple-Aim-Journey.aspx).

Price transparency is another element of healthcare reform with implications for board oversight. The PPACA includes a provision to allow individuals and small employers to select from competing plans offered on health insurance exchanges. As a recent article by Maribeth Shannon of the California HealthCare Foundation pointed out, "Despite changes in health plan benefit designs to promote cost-conscious decision making, the tipping point has not been reached. Not enough patients have incentives to shop based on price, and for those who do, the incentives still are too weak. A \$5,000 deductible becomes moot when any hospitalization is likely to exceed the deductible, regardless of the hospital chosen."<sup>3</sup> Unless Congress tweaks the PPACA to allow consumers to lower cost plans with incentives to choose efficient providers, the value-driven consumer will remain an unfulfilled prophecy. However, consumer-driven health plans may get a boost from re-energizing Republicans in Congress. If they do, and if providers organize into ACOs as planned, competing on value could become reality. The organization's competitiveness on publicly available prices, value, and quality would be a higher priority for board oversight.

## Implications for the Board Quality Committee

All these developments have several implications for what board quality committees should expect from their management and clinical leaders:

1. **Get outside the hospital.** Broaden the organization's strategic quality plan from an inpatient focus to a system-wide focus that includes not only inpatient care but also extends across the continuum to physician groups, medical homes, outpatient care centers, home care, rehabilitative services, and long-term care. When it approves the organization's quality plan, the board quality committee should be sure the plan reflects the shift to accountable care and includes clearly defined initiatives, milestones, and measures.
2. **Expand improvement priorities to include Triple Aim initiatives beyond the hospital.** For example, Baylor Health Care System in Dallas implemented a heart

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- 3 "Transparency's effect unclear," *Modern Healthcare*, November 8, 2010, accessed at [www.modernhealthcare.com/article/20101108/NEWS/101109987&template=printpicart](http://www.modernhealthcare.com/article/20101108/NEWS/101109987&template=printpicart).

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failure clinic to improve follow-up for heart failure patients and prevent readmissions. Launched at Baylor University Medical Center in 2003, the effort included redesigning the patient discharge process to emphasize patient education and attendance at follow-up appointments, as well as sharing information from the clinic with the patient's primary care physician. Follow-up appointments are allowed to occur with either the clinic or the primary care physician, because both have access to the same clinical information. Since the launch of the clinic, "30-day readmission rates have dropped substantially." Overall, Baylor's "best care" program has enabled it to become the third-highest-performing system in the United States in quality performance, out of 73 systems ranked.<sup>4</sup> Similarly, according to IHI's Web site, the Genesys Health System in Flint, Michigan is using a patient-centered medical home and a health navigator to link patients, providers, and community resources. The

effort is demonstrating 10–25 percent lower costs among insured and uninsured populations.<sup>5</sup>

3. **Broaden the quality dashboard to include patient population-based value measures across the care continuum.** These might include, for example, blood pressure control in hypertension patients and per capita costs, ER visits, hospital admissions, medication adherence, and patient-reported health status for such chronic illnesses as pediatric asthma and diabetes.
4. **Ensure that the board quality committee has the right makeup to reflect its new priorities.** Most important, this committee must receive the same priority for top flight members as the finance committee. Interest is no substitute for expertise. The committee needs a hard core of members with knowledge and experience in quality and care management who are willing to ask the hard questions and exercise serious accountability. Some members or staff will

be insiders with familiar faces, such as the chief medical officer, chief quality officer, and chief nursing officer. New insiders may include the leader of the hospital-owned physician group practice or aligned physician enterprises or the chief of medical informatics or quality measurement. Outside directors with experience in quality are also key. These individuals might include executives or academics with expertise in quality control, manufacturing, or service industries (nuclear power, chemical manufacturing, and airlines are especially relevant). Many larger health systems seek both expertise and independence by recruiting a chief medical officer from another hospital or another non-competing system entirely.

No matter what happens in the next Congress, accountable care and the Triple Aim concept are here to stay. Board quality committees should take note and plan their work accordingly. ●

4 Tom Emswiler and Len M. Nichols, New America Foundation, "Baylor Health Care System: High-Performance Integrated Health Care," published by The Commonwealth Fund, available at [www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/March/Baylor%20Health%20Care%20System/1246\\_Emswiler\\_Baylor\\_case\\_study\\_rev.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/March/Baylor%20Health%20Care%20System/1246_Emswiler_Baylor_case_study_rev.pdf).

5 "Achieving the Triple Aim: Summaries of Success," Institute for Healthcare Improvement, accessed at [www.ihl.org/NR/rdonlyres/F5D0A9ED-C14C-4411-9FB1-07821171DF27/0/IHITripleAimOverviewSummariesofSuccessjul09v2.pdf](http://www.ihl.org/NR/rdonlyres/F5D0A9ED-C14C-4411-9FB1-07821171DF27/0/IHITripleAimOverviewSummariesofSuccessjul09v2.pdf).