In September 2012, the American Medical Group Association presented the Acclaim Award to HealthPartners for its initiative “Triple Aim 2.0,” an inventive and patient-centered approach to align the Institute of Medicine’s Aims to identify and drive performance improvement, innovation, and culture throughout the organization. In this article, Dr. Brian Rank, medical director, describes the impetus for the initiative, followed by highlights of the results they have achieved.

**Triple Aim 2.0: Designing Culture and Care to Support Better Health, Better Experience at a Lower Cost**

Part 1: HealthPartners and the Triple Aim

BY BRIAN RANK, M.D.
As a physician, I feel a deep humility and honor to work with patients who have entrusted their lives to our care. As an oncologist, I see patients who are at their most vulnerable; and I can see how unconnected, fragmented care can leave patients lost in the healthcare system. That’s not what we want for our patients, and it’s not what I aspired to when I went into medicine.

The issue, of course, is how to fix it. For colleagues across HealthPartners, Crossing the Quality Chasm, published by the Institute of Medicine a decade ago, remains today our most important blueprint. It argued that “the health care chassis is broken” and that clinicians essentially work devoid of reliable systems—every doctor developing his or her own approaches with no hope of possibly keeping current with new developments in medicine.

We all know the data: in the U.S. it takes an average of 17 years for a clinical best practice to become fully embedded. According to Beth McGlynn of the RAND Corporation, only about 50 percent of the time do people receive the right care. Yet we spend 50 percent more per capita on health care than any other developed country. And doctors and care teams feel overworked and under-supported. Only a broken chassis delivers results like that.

Only by bringing the three elements of the Triple Aim together can we really impact health.

The IOM report envisioned a system that could reliably produce better results: better health for the population we serve; an exceptional experience of care for every patient; and care that is more affordable, or the “Triple Aim.” And it made clear that to do this we would need to change both our culture and how we deliver care. So that’s what HealthPartners set out to do.

We have been very intentional about collaboratively creating a culture to support triple aim outcomes. Our clinicians have been deeply involved and engaged in a dialogue that identified changes both doctors and the organization need to make to build more reliable systems of care and create a better future for our patients and us. Our culture is built into everything we do. We know that to create the outcomes we envision, we must attract and retain colleagues who are passionate about the triple aim.

Creating a culture must be paired with reliable care design. We believe in building a system that standardizes care to the best science, and then customizes to patient preferences, values, and unique human characteristics. Care must be accessible when and how it is most convenient for patients, and coordinated across people, place, and time. All of our improvement projects incorporate these design principles.

Using those design principles across an entire system of care, we focus on measuring, transparently reporting, and improving health and experience outcomes for our patients. At the same time, we now use the NQF-endorsed total cost of care measure to identify where we have the greatest opportunity to improve total cost of care. We must address cost since we are all contributing to the growing percentage of personal income devoted to health care, and diverting dollars from other uses that could have a way greater impact on overall health, like education and other social determinants of health. Only by bringing the three elements of the Triple Aim together can we really impact health. Clinical outcomes are essential, but so are how patients feel they were treated, and so is the cost. We’re entrusted with a precious resource, and the burden is on us to use it wisely.

HealthPartners has grown to more than 800 physicians practicing at 4 hospitals and 25 medical clinics. Our clinics serve 500,000 patients in the greater Twin-Cities metro area and western Wisconsin. Regions Hospital, our largest with 454 beds, is a level 1 trauma and tertiary center, as well as the largest private employer in St. Paul. On January 1, 2013, we joined with Park Nicollet Health Services, another transformative healthcare leader in Minnesota. With the combination, our delivery system will care for a million patients with 1,500 physicians and 5 hospitals. Bringing our organizations together is all about strengthening our ability to deliver on the triple aim across our community.

Brian Rank, M.D., is medical director at HealthPartners Medical Group, the 2012 Acclaim Award recipient.
HealthPartners is a large, consumer-governed, integrated care delivery and financing organization providing care to nearly 500,000 patients with 800 physicians practicing in 35 medical and surgical specialties at 50 locations. Its mission is to improve the health of its members, its patients, and the community.

In alignment with the Institute of Medicine’s Six Aims that serve as foundational guides for its work, HealthPartners has developed a process of proactively identifying improvement opportunities, and built a culture that supports innovation and improvement. They start by identifying priorities using internal and external quality benchmarks, experience outcome measures, utilization metrics, and total cost. The implementation plan is devised by a team consisting of executive sponsorship, project managers, electronic health record experts, quality experts, and clinical experts. The team structures innovation around its design principles of reliability, customization, access, and coordination. The final step in the process is to involve patients when it improves care, because efforts to improve will only be successful if done through the eyes of patients.

HealthPartners has developed a process of proactively identifying improvement opportunities, and built a culture that supports innovation and improvement.

HealthPartners team accepting the 2012 AMGA Acclaim Award (left to right): Brian Rank, M.D., Medical Director; Sue Knudson, Vice President, Informatics; Nancy McClure, Sr. Vice President; Megan Remark, Sr. Vice President, Specialty Care; Beth Averbeck, M.D., Associate Medical Director, HealthPartners Medical Group Primary Care; and Bob VanWhy, Senior Vice President, Primary Care & Practice Development

This proactive, intentional work has led to great results in the organization and the community. By transparently sharing health, experience, and cost metrics, HealthPartners has led innovation that has positively impacted health care for every patient in its community. The organization is the highest performing medical group in Minnesota’s community measurement collaborative, with rates above average on 13 out of 15 clinical measures (its nearest competitor has 10 out of 15 measures). If HEDIS results reflected the medical group’s results, HealthPartners would be ranked third in the nation. As an organization, they have an approach and culture to improve both clinical quality and patient satisfaction in ways that engage employees in the process that make the organization a great place to work and a great place for patients to receive care.

IOM Aims

In 2001, the organization was drawn to the IOM’s Six Aims as a way to define quality and measure improvement. They saw it as the first time that anyone had articulated a set of dimensions where efficiency, effectiveness, safety, and patient-centeredness were all considered elements of quality. The same year the aims were published, they were publically incorporated into the mission, vision, and organizational goals of the organization. In addition, the annual planning process
Leadership

Strong leadership is essential in any journey toward a more ideal healthcare delivery system. Goals and objectives are linked to overall organizational mission and strategic planning through annual planning process and site visits. First, all leaders are required to complete an annual planning worksheet that outlines each of the objectives in the mission statement, and clearly articulate how their area will work to meet the greater goals of the organization’s mission. Strategies and goals are placed into four dimensions: Health, Experience, Stewardship, and People. Secondly, senior leaders annually conduct site visits to all administrative and clinical areas, to share the organization’s goals, how they are performing, and link the work that each area does back to the organizational level. Each site also shares its results in each of the four dimensions.

Implementation Plan

1. Identify Opportunities

First, the organization identifies priorities and opportunities through quality benchmarking, external requirements, and total cost of care results. Quality benchmarking comes through an internal review of quality health and experience outcome measures, which are benchmarked against an organizational-wide goal. External quality benchmarking is done through a state-wide reporting collaborative. External measure requirements include state and national certifications for healthcare home, NCQA standings, and HEDIS measures. They also use a nationally recognized total cost of care measure from their health plan to identify opportunities based on cost and benchmarked against statewide and metro averages.

2. Build a Team

Second, leadership prioritizes projects based on the list of opportunities, and builds a team to simultaneously impact all aspects of the Triple Aim in a project. To do the work, the team will use quality tools like Lean rapid action teams, expert panels, case studies, or data analysis to build the timeline and work plan for the projects.

3. Redesign Care

HealthPartners deploys “Care Model Process” (care redesign) steps of reliability, customization, access, and coordination as the framework to build to Triple Aim results, starting with a consistent approach to deliver reliable, standardized care. This means care is based on best evidence, it is built into the electronic health record with decision support tools, processes are standardized

safe: Standing orders for lab tests, prescription refills, warfarin protocol, and opioid management.

timely: 30% same-day access in primary care, as well as same-day urgent specialty access and urgent care sites open 9:00 a.m. to 9:00 p.m.
effective: Evidence-based care with electronic health record decision support.
efficient: E-visits and scheduled phone visits for patients, within fee-for-service reimbursement model; 24-hour online convenience clinic.
equitable: Reduced disparities in colorectal screening and mammograms (see Figures 1 and 2)
patient-centered: Test results are available online within four hours. Wait times for urgent care and emergency departments are posted online. Patients are included in shared decision making, where the doctor and patient look at all treatment choices and pick what most fits with the patient’s unique preferences and values. Education materials and patient satisfaction surveys are available in the patient’s preferred language.

The Commonwealth Fund’s six attributes of an ideal healthcare system have also been incorporated into the healthcare delivery system throughout its decade of continuous redesign.

Culture Change

The most critical changes and the most important challenges revolved around culture; changing the culture of a system is challenging and crucial to improving care for patients. In 2006, HealthPartners completed the Physician & Dentist Partnership Agreement, outlining the organizational and doctor “gives” that identified the changes both parties needed to make to achieve the vision of a better future for patients. For example, one physician give is to “reduce unnecessary variation in care to support quality, reliability and customized care based on patient needs.” The partner organizational give is to “provide an environment and tools for a satisfying and sustainable practice.” One simple example of how they are meeting this promise is a “click reduction” initiative. In 2010 they reduced electronic health record clicks by roughly 2 million, and by 6.7 million in 2011. This Partnership Agreement is built into day-to-day processes, and it's included in physician orientation and annual performance evaluations for doctors and leaders. Additionally, the Medical Director reviews the agreement with all new doctors before they are hired, to ensure the best cultural fit on both sides.
to reduce variation, every care team member contributes to their maximum potential, and waste and rework that add unnecessary costs are continuously eliminated.

After they standardize to the science, they customize to individual patient preferences and values. Disparities working to close the gap between white patients and patients of color (Figures 1 and 2), as previously described, is a good example of how they customize. Same-day mammograms, outreach calling, and even special days for mammograms for a specific culture (i.e., Somali and Hmong) are offered to improve screening rates.

After customizing, HealthPartners designs ways to make care and information more convenient, easier to access, and affordable. Patients have 24/7 access to care. Patients can access care traditionally, in person, through scheduled or same-day availability, urgent care, or worksite clinics. They can call, and have scheduled phone visits with their provider or a member of their care team, or they can access care virtually by sending their provider and care team an e-message, and they will receive a response within 24 hours.

Finally, care is coordinated across sites, specialties, and time. For example, cancer pathways automatically coordinate care when a patient is suspected of having a cancer. For lung cancer, the primary care physician enters an order into the electronic health record, and the pulmonologists and oncologists are able to pick up the order and coordinate the care. Patients are assigned a nurse care coordinator through the process, so they always have a contact person who is familiar with their situation and can respond if they have questions or concerns.

HealthPartners has been able to reduce hospital readmissions through collaboration of the hospital, clinics, care management, and pharmacy services (see Figure 3).

4. Involve Patients

The final, and most important step, is to always look at everything they do through the eyes of their patients. HealthPartners knows that efforts to achieve the Triple Aim will fail if they don’t. They involve patients by using focus groups, patient councils, and survey comments to inform the impact and direction of initiatives.

Example: Population Health

A specific project implemented using this approach is called “Population Health,” essentially the next phase of the Medical Home. The Population Health framework is a care model developed and used in the

---

FIGURE 1
Reducing the Gap; Breast Cancer Screening, 2007-2012

FIGURE 2
Reducing the Gap; Colorectal Cancer Screening, 2009-2012

FIGURE 3
Reducing Hospital Readmissions

Reduce readmissions through collaboration of hospital, clinics, care management, and pharmacy services.

- Identify high-risk patients
- Create care plans and implement health coaching
- Participate in medication "boot camp"
- Schedule orders for follow-up clinic appointment
- Coordinate care with home care and other resources
- Simplify patient discharge instructions
- Engage patients in "teach back" methods
- Call patients post discharge

---

2/11/13 10:16 AM
medical group to improve health and experience for patients who are the highest utilizers of care. The work is specifically focused on developing care plans, shared goals with patients using health coaching, improved coordination of care, and accessibility across the system.

The care model flow for these focus populations begins when the care team nurse uses a stratification list created through the medical record to identify patients who have more complex care needs. This nurse then completes a pre-visit assessment either by phone or in person when the patient is already scheduled for an appointment. The physician’s role is to review the assessment, complete diagnoses and treatment plans, and then provide a summary to the nurse. After the full assessment with the care team, the patient is given a customized care plan, which may include working with a resource across the continuum of care, such as the pharmacist, the care coordinator, a disease or case manager, specialty, or an external community resource.

The specific strategies that have led to results include:

- **Care Plan:** A brief summary of significant conditions that put the patient at risk for hospitalization and emergency department along with recommended care to prevent hospitalization; serves as a guide for other care teams

- **Shared Visits:** Between the physician and the RN, where the RN is able to spend more time with patient on education, and ensuring understanding of the care plan and physician instructions

- **Tiering:** To stratify and prioritize care paths for patients

- **Behavioral Health:** Triaging and access for patients in crisis; defined paths of care for patients with mild, moderate, and severe conditions

- **Opioid Use:** Patient agreements for opioid prescription, regular drug testing, partnership with MTM (Medication Therapy Management) pharmacist for tapering of medications

Outcomes of the Population Health work thus far have included improved patient health, improved patient experience, and improved stability in the high-risk population that has reduced the total cost of care, hospital admissions and readmissions, length of hospital stays, emergency department visits, and urgent care visits. A specific example is a reduction in cost of $500,000 in two months after implementing care plans for a subgroup of patients who were frequently accessing the emergency department requesting pain medication.
Triple Aim 2.0

The goal isn’t to do a project here and there; it’s to redesign the system so that it is capable of continuously innovating to produce Triple Aim results. And, as HealthPartners has worked on this over the last decade, it’s become clear that there are several elements that are essential to creating that system. They use the Care Model Process redesign elements of reliability, customization, access, and coordination to home systems, and have produced top-level results both for the organization and patients. They’ve essentially taken the Triple Aim to the next level and call it “Triple Aim 2.0.”

Staff are educated about the goals of the project and implementation plans through “Care Model Process Upgrades,” which are periodic retraining and educational sessions that help bring all staff up-to-date on new processes and goals. They use leader rounding, site visits, annual plans, and internal communications to keep employees connected to the work. They also have a train the trainer program, where learners provide feedback to the trainers on what works and what doesn’t. For experience goals, they have a voluntary Shadow Coaching program where providers are observed by a coach who is a non-clinician employee, trained to make observations and give feedback related to the experience aspect of the Triple Aim.

Results

HealthPartners uses internal benchmarks and external benchmarks like HEDIS and state-wide community reporting collaborative to transparently report results. They annually set goals internally, and work to be the best care group in their market and the nation. Data is collected by their informatics and care innovation teams using the electronic health record, validated and standardized both internally and externally.

They have developed an internal measure to track results related to the Triple Aim goals (Figure 4). Diabetes is used as a proxy measure of health. This measure was chosen because of its prevalence and cost of complications if not managed well. In the community, they use an all-or-none measure of best care in diabetes where patients need to meet all parameters (lipid, blood pressure, glycemic control, no tobacco use, and aspirin if coexisting heart disease). They have improved care for patients with diabetes and at the same time decreased the incidence of cardiovascular disease, amputations, and retinopathy by 50%. Best care for diabetes results in a decreased cost of care of $6,000 per patient per year.

The organization reports on the patients who would recommend the care system to their friends and family, and finally they look at total cost of care for...
patients as an index compared to the state average. The transformation of care has helped HealthPartners improve the quality of health for patients at an exceptional experience, with a total cost that is 11% lower than the state average.

The care model provides the opportunity to recommend needed care at all touch points for patients. Figures 5 and 6 display the local collaborative results (HealthPartners is circled in red) as well as recent HEDIS results. If HEDIS results reflected the medical group results, HealthPartners would be third in the nation.

Inspiring Dramatic Organizational Change

HealthPartners believes organizations wishing to implement a dramatic organizational change need to follow the key elements below to redesign the care process and achieve Triple Aim results.

■ A clear vision. A clear, shared vision among the board members and senior leaders cascading throughout the organization is essential. Progress toward the vision requires setting ambitious goals and transparently reporting results.

■ Cultural change. The cultural change required to succeed with team-based medicine is considerable. The organizational culture needs to embrace standardization and reliability and to act every day on the belief that the center of the care is the patient.

■ A Triple Aim focus. Measuring progress on all three elements of the Triple Aim simultaneously is a powerful way to keep an organization on track.

■ The right leadership structure. HealthPartners’ leadership system pairs an administrative leader and a physician leader in each area. The two manage their areas as a team, agreeing on all decisions before any changes are made. This unites the two sometimes quite different administrative and clinical points. Together, they see the whole picture.

■ Teamwork. The Triple Aim 2.0 vision works, in part, because the teams are working in new ways to have individuals working to their full capabilities, to huddle and design care together, and in new roles and new communication processes.

■ Design principles. In order to practice design with intention, apply design principles across the system: reliability, customization, access, and coordination. The EHR is essential, but it is not sufficient on its own to drive change.

■ Involvement of patients and families. It really changes the focus of the discussion and enhances the care design to have patients involved.

References


Adapted from the 2012 Acclaim Award Application of HealthPartners submitted by Beth Waterman, R.N., M.B.A., chief improvement officer.