The Institute for Healthcare Improvement (IHI) believes that new designs can and must be developed to simultaneously accomplish three critical objectives, or what we call the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

The IHI Triple Aim team has put together a prudent set of suggested measures that also help operationally define the Triple Aim.

Dimension	Measure
Population Health	1. Health/Functional Status: single-question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol)
	2. Risk Status: composite health risk appraisal (HRA) score
	3. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions; summary of predictive model scores
	4. Mortality: life expectancy; years of potential life lost; standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/*
Patient Experience	1. Standard questions from patient surveys, for example: -Global questions from US CAHPS or How's Your Health surveys -Experience questions from NHS World Class Commissioning or CareQuality Commission -Likelihood to recommend
	2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)
Per Capita Cost	1. Total cost per member of the population per month
	2. Hospital and ED utilization rate

The primary issue with measurement is how to use it at various levels and for various purposes. By now the IHI team has heard a set of frequently asked questions or concerns regarding measures. Below is a list of questions or concerns and proposed answers.

Frequently Asked Questions and Concerns

- *The measures you propose are too high level. They are not actionable.*
- *The data are not current and useful.*
- *How long will it take to move these high level measures?*

- *The data are not aggregated at a useful level.*

  The measures you propose are too high level. They are not actionable.

  High level measures, such as years of potential healthy life lost, are useful for operationally defining health and for establishing long range, 5-10 years, plans. Publically available data such as Hospital Compare or CAPHS from CMS or some the NCQA measures would be useful at a project level. Hospitals, doctors and other providers can and should develop the capability to use their existing data for improvement.

  The data are not current and therefore not useful.

  It is true that some publically available data are a year or more behind. This limits their use in providing real time or even quarterly feedback to guide improvement efforts. However, they can be useful in several ways. One is to compare trends in the data against other comparison groups such as national or state results. Without some aggressive initiatives to change the relative results high level measures will be stable with respect to these comparison groups. They then are useful for building will and setting priorities. For more timely feedback these publically available data can be supplemented locally by utilization data from health plans for the under 65 year old population. Quality Improvement Organizations contracted in each state by CMS have access to current Medicare data. The trends in some of these "drill down" data sources can be confirmed by the "official" data when they are available. For example, suppose a region provided equitable access to primary care and developed an integrated approach to chronic disease prevention and treatment. The region might expect to see an improvement in the self reported health status for people making less than 50,000 per year when the data becomes available.

  How long will it take to move these high level measures?

  Of course for some initiatives there will be a delay between cause and effect. However, important measures such as self reported health status, readmission rates, admissions for exacerbations of chronic illness, trends in per capita cost can all be impacted in a three year period. It is useful to develop goals for 1, 3 and 5 year periods. Perhaps the most important factor in determining the speed at which results are produced is the capability and capacity for improvement in the region.

  The data are not aggregated at a useful level.

  This is often the case. Perhaps county data is needed but the data are aggregated only at the state level. Sometimes county data are available but target populations are mostly resident in a few zip codes. Often the reason the data are not available is that the researchers believe that the sample sizes are too small at these small geographic regions. This is probably true for one time snapshots. But a region with a sustained focus on the Triple Aim will accumulate years of data in these focused areas that can be plotted over time and analyzed using control chart methods. The Commonwealth Fund Team (now residing at IHI) that produces the state scorecards is completing a project to disaggregate the data into smaller geographic groupings.

  A general principle to be used when establishing a regional measurement strategy is that the publically available data will be somewhat useful but will not be exactly on target. Ingenuity will be needed to define surrogate measures that are more targeted but less rigorous. These measures can provide useful feedback for learning. For example, it may be very difficult to get overall health

spending in a region for the commercially insured population. However, the hospitals and some of the businesses could contribute their figures on yearly health care premium increases as an indicator of per capita cost trend. Emergency departments must report data on volume and condition to local health departments for surveillance purposes. These data could be used a source of data on trends in population health or health care experience.

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Two Years Later: The Benefits of the Affordable Care Act for Florida

For too long, too many hardworking Americans paid the price for policies that handed free rein to insurance companies and put barriers between patients and their doctors. The Affordable Care Act gives hardworking families in Florida the security they deserve. The new health care law forces insurance companies to play by the rules, prohibiting them from dropping your coverage if you get sick, billing you into bankruptcy because of an annual or lifetime limit, or, soon, discriminating against anyone with a pre-existing condition.

All Americans will have the security of knowing that they don't have to worry about losing coverage if they're laid off or change jobs. And insurance companies now have to cover your preventive care like mammograms and other cancer screenings. The new law also makes a significant investment in State and community-based efforts that promote public health, prevent disease and protect against public health emergencies.

Health reform is already making a difference for the people of Florida by:

Providing new coverage options for young adults

Health plans are now required to allow parents to keep their children under age 26 without job-based coverage on their family's coverage, and, thanks to this provision, 2.5 million young people have gained coverage nationwide. As of June 2011, 157,185 young adults in Florida gained insurance coverage as a result of the new health care law.

Making prescription drugs affordable for seniors

Thanks to the new health care law, 256,600 people with Medicare in Florida received a $250 rebate to help cover the cost of their prescription drugs when they hit the donut hole in 2010. In 2011, 238,362 people with

Medicare received a 50 percent discount on their covered brand-name prescription drugs when they hit the donut hole. This discount resulted in an average savings of $596 per person, and a total savings of $141,948,339 in Florida. By 2020, the law will close the donut hole.

Covering preventive services with no deductible or co-pay

In 2011, 2,581,961 people with Medicare in Florida received free preventive services – such as mammograms and colonoscopies – or a free annual wellness visit with their doctor. And 54 million Americans with private health insurance gained preventive service coverage with no cost-sharing, including 2,841,000 in Florida.

Providing better value for your premium dollar through the 80/20 Rule

Under the new health care law, insurance companies must provide consumers greater value by spending generally at least 80 percent of premium dollars on health care and quality improvements instead of overhead, executive salaries or marketing. If they don't, they must provide consumers a rebate or reduce premiums. This means that 4,185,000 Florida residents with private insurance coverage will receive greater value for their premium dollars.

Removing lifetime limits on health benefits

The law bans insurance companies from imposing lifetime dollar limits on health benefits – freeing cancer patients and individuals suffering from other chronic diseases from having to worry about going without treatment because of their lifetime limits. Already, 5,587,000 residents, including 2,170,000 women and 1,411,000 children, are free from worrying about lifetime limits on coverage. The law also restricts the use of annual limits and bans them completely in 2014.

Creating new coverage options for individuals with pre-existing conditions

As of the end of 2011, 3,736 previously uninsured residents of Florida who were locked out of the coverage system because of a pre-existing condition are now insured through a new Pre-Existing Condition Insurance Plan that was created under the new health reform law. To learn more about the plan available in Florida, check here.

Supporting Florida's work on Affordable Insurance Exchanges

Florida has received $1 million in grants for research, planning, information technology development, and implementation of Affordable Insurance Exchanges.

- ***$1 million in Planning Grants:*** This grant provides Florida the resources needed to conduct the research and planning necessary to build a better health insurance marketplace and determine how its exchange will be operated and governed. Learn how the funds are being used in Florida here.

Preventing illness and promoting health

Since 2010, Florida has received $34.8 million in grants from the Prevention and Public Health Fund created by the Affordable Care Act. This new fund was created to support effective policies in Florida, its communities, and nationwide so that all Americans can lead longer, more productive lives.

Increasing support for community health centers

The Affordable Care Act increases the funding available to community health centers in all 50 states, including the 379 existing community health centers in Florida. Health centers in Florida have received $81.4 million to create new health center sites in medically underserved areas, enable health centers to increase the number of patients served, expand preventive and primary health care services, and/or support major construction and renovation projects.

Strengthening partnerships with Florida

The law gives states support for their work to build the health care workforce, crack down on fraud, and support public health. So far, Florida has received more than $143.1 million from the Affordable Care Act. Examples of Affordable Care Act grants not outlined above to Florida include

- **$3.3 million for health professions workforce demonstration projects**, which will help low income individuals receive training and enter health care professions that face shortages.
- **$600,000 for the expansion of the Physician Assistant Training Program** (PDF – 66 KB), a five-year initiative to increase the number of physician assistants in the primary care workforce.
- **$3 million to help Florida reduce health care fraud** by identifying efficient and effective procedures for long-term care facilities to conduct background checks on prospective employees, thereby protecting its residents.
- **$3.1 million for school-based health centers**, to help clinics expand and provide more health care services such as screenings to students.
- **$1.4 million to support outreach to eligible Medicare beneficiaries** about their benefits.
- **$164,000 for Family-to-Family Health Information Centers**, organizations run by and for families with children with special health care needs.
- **$8.3 million for Maternal, Infant, and Early Childhood Home Visiting Programs**. These programs bring health professionals to meet with at-risk families in their homes and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn - such as health care, early education, parenting skills, child abuse prevention, and nutrition.

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