

Editorial

Leveraging the integrated patient-centered care model to achieve the “Triple Aim”

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The world is in a transition toward significant older populations. As people across the world have longer lifespans, growing burden of chronic illness are poised to become a major health care challenge, which requires effective strategies to address the problems. Evidence shows that health systems oriented around the needs of people and in an integrated way are more effective, efficient, improve health outcome, and are better prepared to respond to health crises. With the World Health Organization (WHO) recently calling for a fundamental paradigm shift in the way health services are funded, managed and delivered, the integrated patient-centered care comes up as a reformed care model, to empower patients, fight health system fragmentation and foster greater coordination and collaboration with organizations and providers across care settings, to deliver health services that are aligned with the needs of people [1].

The integrated people-centered care is an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. It requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases [1].

In 2008 the Institute for Healthcare Improvement (IHI) first developed the Triple Aim to optimizing health system performance, including simultaneously improving population health, improving the patient experience of care, and reducing per capita cost [2]. It has since become the overarching goal of optimizing healthcare systems, as well as the driving force behind government healthcare policy and funding. It's important to point out this framework is called the Triple Aim rather than the Triple Aims, since all three components must be balanced and addressed simultaneously in order to reach the goal. Only focusing on individual elements is not enough to reform healthcare.

The key to achieve the “Triple Aim” in health care is to meet the needs of high-need and high-cost patients. The implementation of integrated patient-centered care model has demonstrated success in meeting the needs of this subgroup of patients. Take older adults with chronic conditions as an example, this subgroup of population is very heterogeneous in health status, disease severity, treatment options, prognosis and risk of adverse events [3]. Existing literature suggests that the optimal management of chronic conditions depends highly on active involvement of the patients. In United States, the concept of patient-centered care has become an essential component

in the healthcare sector since the 1950s [4]. Patient-centered care is principally described as an effective approach to deliver care that meets the specific needs, values, and beliefs of patients in United States [3]. A significant increase in its popularity starts to emerge over the past 15 years, presumably because primary care systems are seeking solutions to the cope with the challenges from the population aging and significant burden of chronic conditions.

In 2007, the American Academy of Pediatrics (AAP) joined with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) released the Joint Principles of the Patient Centered Medical Home (PCMH or medical home), which is generally described as a model or philosophy of patient-centered care, that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions [5,6]. Additionally, the PCMH model focuses on chronic condition management, shared decision making with patients, enhanced access, and coordination with community-based services [7].

Although integrated patient-centered care model has been theoretically conceived being able to overcome current challenges from fragmentation and poor coordination of care, more evidence is expected to assess whether the model is appropriate for delivering chronic care to aged patients with high-risk or complex healthcare needs. Further investigations are need to tailor the model according to the needs of specific patient population, the nature of their diseases, and other predisposing or enabling factors.

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