

What's Missing From the Triple Aim of Health Care?

It's time to prioritize worker satisfaction, along with the aims of patient experience, population health, and cost reduction.

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In October 2007, the Institute for Healthcare Improvement (IHI) launched the Triple Aim Initiative. As depicted in Figure 1,¹ the initiative was designed for health organizations to simultaneously pursue three dimensions²: improving the health of populations; improving the patient experience of care (including quality and satisfaction); and reducing the per capita cost of health care. Since then, the Triple Aim has become an iconic moniker to represent the bar that health care strives to meet.

WHY THE TRIPLE AIM?

The United States' health care system is often referred to as the most costly in the world, with comparative analyses consistently suggesting that the United States underperforms on most dimensions of health care performance relative to other countries.³ Our aging population and increased longevity, coupled with chronic health problems, have become a national challenge, putting new demands on medical and social services.

The premise behind the Triple Aim was that pursuing its three objectives at once allows health care organizations to identify and fix problems, such as poor coordination of care and overuse of medical services. It was also intended to help health care organizations focus on and redirect resources to activities that have the greatest impact on health.

Today, in most health care settings, no one is accountable for all three dimensions of the Triple Aim. Yet, to improve the health of our communities, the experience of patients and families, and slow the growth of health costs—and because it demands a

systematic approach to improvement at all levels of the health care system—IHI contends that we need to address all three of the Triple Aim dimensions concurrently.

This is no small task; it will require changing the overall clinical delivery model and the way physicians and other clinicians perform their duties (both individually and in teams), while supporting them with vastly improved informative data and resources (people and otherwise) to make the changes.

To accomplish the Triple Aim, the IHI recommends a change of process that includes identification of target

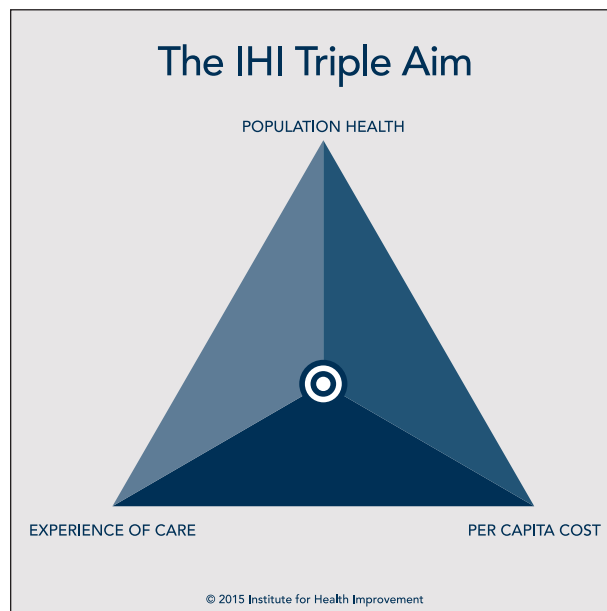


Figure 1. The Institute for Healthcare Improvement's Triple Aim Initiative.



Figure 2. The Fourth (missing) Aim is improved clinician experience.

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.

In 2009, the IHI launched the “Joy in Work” initiative,⁴ one of IHI’s 10 ways to radically transform health care. The initiative calls for organizations to, “Create joy in work by cultivating and mobilizing the pride and happiness of the health care workforce.”⁵ The IHI now offers a variety of educational options for leaders to learn more about adopting Joy in Work strategies in their organization.

IHI further believes that in order to do this work effectively, it is important to harness a range of community determinants of health, empower individuals and families, substantially broaden the role and impact of primary care and other community-based services, and ensure a seamless journey across the system of care throughout a person’s life.

Finally, it is thought that the Triple Aim can be a foundational element of many areas of health reform, including accountable care organizations, bundled payments, and other innovative financing approaches; new models of primary care, such as patient-centered medical homes; sanctions for avoidable events, such as

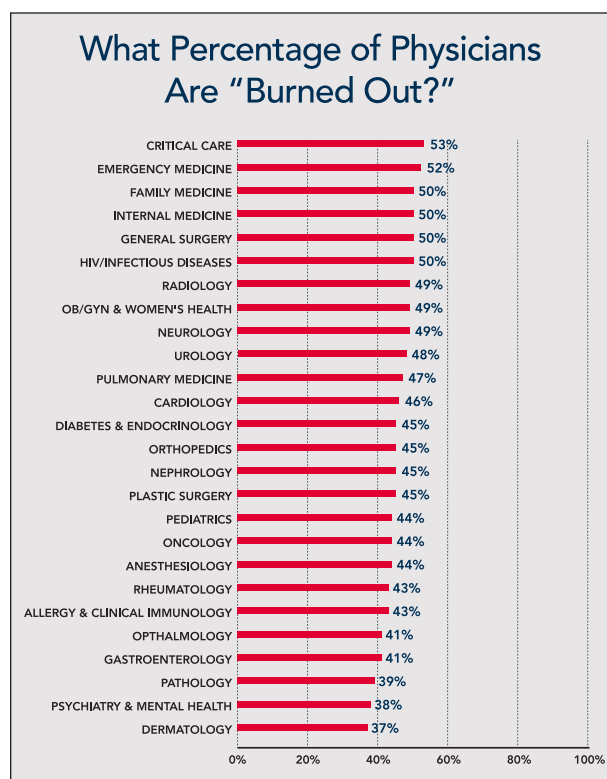


Figure 3. Recent data from Medscape show that burnout is not limited to a certain physician type.

hospital readmissions or infections; and the integration of information technology.

Since 2007, the IHI’s Triple Aim has symbolized health care’s patient-centered focus. Nine years later, many providers within the health care industry believe it is time to modernize the concept. The concern is that the Triple Aim is lacking a fourth fundamental element; the Triple Aim fails to acknowledge health care workers’ critical role in delivering on the initial three aims. The question now is not whether staff happiness and retention are important (it is obvious that they are), but whether these goals deserve to be prioritized alongside the aims of patient experience, population health, and cost reduction.

THE FOURTH (MISSING) AIM

As first noted by Bodenheimer and Sinsky in 2014,⁶ it is suggested that the Triple Aim be replaced with a more appropriate and realistic Quadruple Aim to fully acknowledge that without improving the clinician and caregiver experience, the original three goals of the Triple Aim simply won’t happen. As displayed in Figure 2, the missing aim of “Improved Clinician Experience” completes the Quadruple Aim.

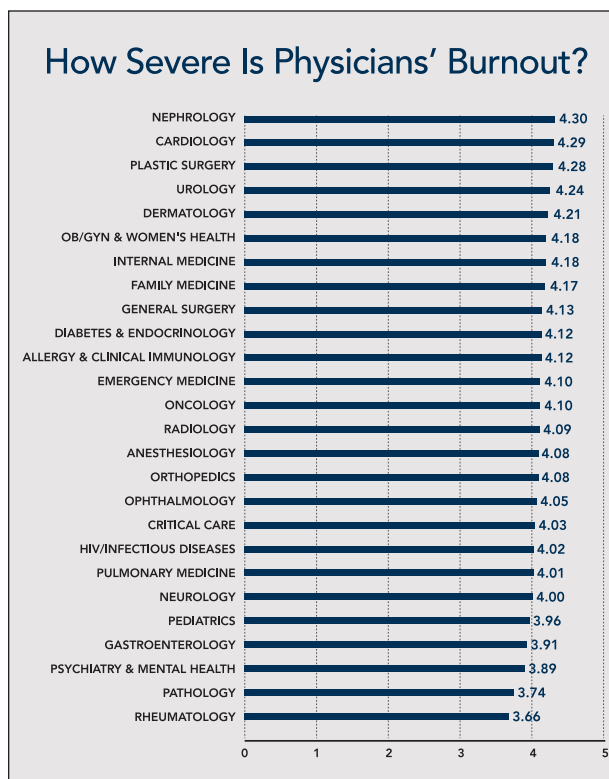


Figure 4. Cardiologists rank number 2 in terms of severity of physician burnout, according to Medscape data.

Speaking to physicians and other caregivers, one often hears stories of the alarming levels of stress and burnout health professionals experience. Never have these issues been more important, as an abundance of research indicates that many health care workers not only fail to find joy and meaning in their work, but are also at risk of serious physical and psychological harm on the job.

Recently, the Mayo Clinic published a study comparing burnout and satisfaction with work–life balance in physicians and the general United States working population between 2011 and 2014.⁷ The survey revealed that 54% of participating physicians reported at least one symptom of burnout in 2014 versus 45.5% in 2011. Furthermore, satisfaction with work–life balance declined from 48.5% to 40.9% during the same period. In contrast, minimal changes in burnout or satisfaction with work–life balance were observed between 2011 and 2014 in probability-based samples of working United States adults not in the health industry.

These results mirrored an earlier national study evaluating rates of burnout among United States physicians, which explored differences by specialty or compared physicians with United States workers in

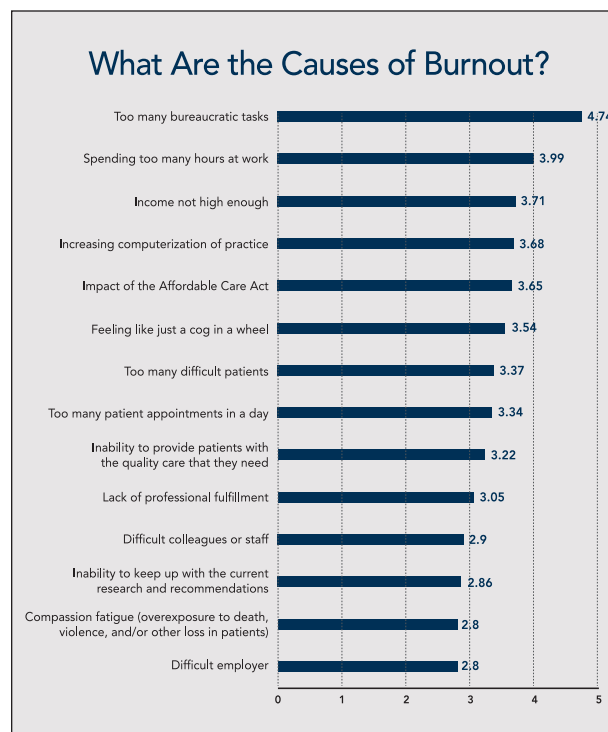


Figure 5. The issues that cause burnout in health care professionals, according to a recent Medscape report.

other fields.⁸ Data from a recent Medscape report show that burnout is not limited to a certain type of physician (Figures 3 and 4).⁹

Physicians are not the only health care professionals affected by burnout. Data related to nursing and other health care professionals also show high levels of burnout and depression; similar to physicians, the reasons often cited include increasing administrative (nonclinical) tasks, heavy patient loads, smaller staffs, and higher stress levels. Even receptionists struggle with trying to meet both patient and doctor demands, with one study finding that 68% of receptionists reported being verbally abused by patients.¹⁰

THE LOSS OF JOY IN HEALTH CARE

There are many factors contributing to increased stress and burnout. Consider the following as just a sample of the additional demands placed on health care workers:

- More stringent documentation demands
- Increasing patient expectations
- Online ratings
- Government regulations
- Greater administrative task burden
- An aging population with complex needs



Figure 6. The hierarchy of needs of health care professionals.

It cannot be emphasized enough how much electronic health records have had unintended consequences, in many ways negatively, in the daily lives of health care workers. A 2014 study¹¹ found that electronic health record functionalities, such as patient email portals, physician order entry, alerts, and reminders, are directly associated with increased provider burnout and intent to leave health care practice.

In addition, our growing aging population means that health care workers are treating an increasingly older, sicker, and therefore more complicated, set of patients.¹² Furthermore, in some cases, this increased workload is overwhelming available resources. Based on a 2012 compilation of state workforce studies and reports, every state needs more physicians. There are shortages of primary care physicians and specialists,¹³ and in fact, numerous health professions—dental, mental health, pharmacy, and allied health—are facing personnel shortages.

Driven by lower reimbursement rates and decreased margins of labor, personnel shortages disrupt work flows, work relationships, and shift duties to already overburdened workers. Hospitals laid off 6,000 workers in 2012, and more than 3,000 workers were affected by buyouts, attrition, or reductions in hours.¹⁴ The increased work-related stress from downsizings undoubtedly affects the mental and emotional health of medical professionals and, therefore, their ability to optimize care.

Another factor is related to the increase in nonclinical work that has shifted to clinicians. Health care has

been increasingly drowning in regulatory-related tasks. Since 1997, the federal government has issued 100 new or revised federal health care regulations, not including countless state and local regulations. The result is that 1 hour of patient care in the emergency room is estimated to require 1 hour of paperwork, and 1 hour of patient care in an acute care unit is estimated to require 36 minutes of paperwork.¹⁵ There are many other factors contributing to burnout. Figure 5 shows some of the different issues that are decreasing the joy in going to work for many health care professionals.¹⁶

INSTITUTING THE FOURTH AIM

Although more organizations, such as Ascension Health (the nation's largest not-for-profit health care system) and the American Nursing Association are beginning to incorporate "Quadruple Aim" into their vernacular, there are still many unanswered questions as to how to best identify and address those tactics that will achieve a greater joy at work for physicians, other clinicians, and every employee involved in patient care. Authors Leonard Kish and Dave Chase write, "Winning health care delivery organizations recognize that the Quadruple Aim will deliver sustainable success. The 'forgotten aim' is a better experience for the health professional. Layering more bureaucracy on top of an already overburdened clinical team ignores that the underlying processes are frequently underperforming and that a bad professional experience negatively impacts patient outcomes."¹⁷ Dr. Matthew Katz notes, "Healers need to be healthy first—just like patients," and outlines that they have a hierarchy of needs that need to be met, similar to patients having a hierarchy of needs that must be met (Figure 6).¹⁸

Clearly, the Quadruple Aim concept is still in its infancy. Moving forward, the inescapable question is: Can health care achieve the Triple Aim without engaged and satisfied clinicians? Many are saying "no," and some progressive organizations are already replacing the Triple Aim with the Quadruple Aim as their stated goal. The follow-up questions may be: Is the lack of joy and dangerous levels of stress being acknowledged and addressed as quickly or as broadly as they should? And, what specific actions will address them to the point of measurable progress?

As health care works toward transformation, it seems to be time to call attention to the epidemic levels of stress and burnout that industry professionals are facing. It is time to figure out how to make the fourth aim a number one priority so that the other three aims have a chance to succeed. ■

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1. The IHI triple aim initiative. Institute for Healthcare Improvement. <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx>. Accessed January 28, 2016.
2. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27:759-769.
3. Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall, 2014 report: how the performance of the US health care system compares internationally. The Commonwealth Fund. <http://www.commonwealth-fund.org/publications/fund-reports/2014/jun/mirror-mirror>. Published June 16 2014.
4. Build joy in work and prevent burnout. Institute For Healthcare Improvement. <http://www.ihl.org/resources/Pages/AudioandVideo/WIHIRaisingJoyintheHealthCareWorkforce.aspx>. Published July 9, 2009. Accessed February 7, 2016.
5. Stempniak M. IHI lays out 10 ways to radically transform health care. *Hospitals & Health Networks*. <http://www.hhnmag.com/articles/6569-ihl-lays-out-10-ways-to-radically-transform-health-care>. Published October 7, 2015. Accessed February 7, 2016.
6. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12:573-576.
7. Shanafelt T, Hasan O, Dyrbye L, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*. 2015;90:1600-1613.
8. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172:1377-1385.
9. Peckham C. MedScape lifestyle report 2016: bias and burnout. Medscape. <http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview>. Published January 13, 2016. Accessed January 28, 2016.
10. Dixon C, Tompkins C, Allgar V, Wright N. Abusive behavior experienced by primary care receptions: a cross sectional survey. *Fam Pract*. 2004;21:137-139.
11. Babott S, Manwell L, Brown R, et al. Electronic medical records and physician stress in primary care: results from the MEMO study. *J Am Med Inform Assoc*. 2014;21:e100-e106.
12. Can the US meet its aging population's health care needs? University of Pennsylvania, Knowledge@Wharton. <http://knowledge.wharton.upenn.edu/article/can-the-u-s-meet-its-aging-populations-health-care-needs/>. Published March 18, 2013. Accessed January 31, 2016.
13. Recent studies and reports on physician shortages in the US. Association of American Medical Colleges. <https://www.aamc.org/download/100598/data/>. Published October 2012. Accessed January 31, 2016.
14. Graham J. Hospital layoffs pick up as Obamacare era starts. *Investor's Business Daily*. <http://news.investors.com/071913-664373-hospitals-cut-jobs-on-obamacare-medicare-medicaid.htm>. Published July 19, 2013. Accessed October 22, 2013.
15. Patients or paperwork? the regulatory burden facing America's hospitals. American Hospital Association. <http://www.aha.org/content/00-10/FinalPaperworkReport.pdf>. Accessed January 31, 2016.
16. Peckham C. MedScape lifestyle report 2016: bias and burnout. Medscape. <http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview>. Published January 13, 2016. Accessed January 31, 2016.
17. Chase D, Kish L. 95 theses for a new health ecosystem. Medium. <https://medium.com/@healthrosetta/95-theses-for-a-new-health-ecosystem-b32d0cdce2ce#pzzjick7>. Published May 3, 2015. Accessed February 7, 2016.
18. Keefe B, Katz M. Quadruple aim: care of the provider. *Healthcare Leadership Blog*. <https://hclbr.wordpress.com/2015/07/18/quadruple-aim/>. Published July 18, 2015. Accessed February 7, 2016.

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