The Three Confounding Elements of the Triple Aim

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The United States health care system has been described as inefficient, delivering inconsistent levels of care and inordinately expensive; the question is not if it needs transformation but how to do so. In 2008, Donald Berwick and associates described the Triple Aim, in which improving the patient's experience of care, improving the health of populations of patients, and reducing the per capita cost of care may lead to a high-quality health care system, facilitating this transformation.[1]

Several issues have since evolved, impeding the Triple Aim from attaining its goals. Although several could be cited, three are of primacy: the decline of primary care, physician burnout, and the accumulating amount of unmeaningful work for practicing physicians. These three confound the Triple Aim, act as barriers to any meaningful transformation, and need mitigation to move forward; they also may be interrelated and irreducible to the extent correcting one requires correcting all.

Primary care continues to decline.[2] Despite several studies showing a strong primary care presence improves a community's health care outcomes,[3] it continues to be underfunded, challenged in recruiting medical students, and increasingly fragmented.[4-6]

Primary care spending, an index for primary care funding, has remained historically low in the United States at 5.5% to 7.1% and compares unfavorably with other countries.[7] This may partially explain the comparatively low income of generalist specialists and why medical students choose primary care in anemic numbers.[8] Medical student recruitment also is challenged by primary care's demising prestige, which has been exacerbated by the recent political demands to expand scope of practice laws by other health care professions. Medical students may pause and consider that their education is now societally perceived to be not necessary in order to deliver presumptively equitable primary care. Primary care also has become more fragmented and difficult to manage. Generalists, increasingly electronically isolated and unaware of their patient's location in the medical neighborhood, may believe the "chart on the rake" is quiescent when, in fact, the patient is in a nearby intensive care unit (ICU).[9] Patients, encouraged to be health care consumers, seek alternative modes of care outside their generalist's purview, circumventing and minimalizing the patient-physician relationship.[10]

Team-based care and patient-centered medical home initiatives, among other developments, may reverse some of these trends. More innovated interventions are needed, as the decline of primary care adversely affects the Triple Aim by limiting access to the high level of quality care it implicitly requires.

> Of the three confounding issues to the Triple Aim, unmeaningful work may be the least understood and its adverse effects on primary care and physician burnout most underappreciated

The effects of physician burnout on physicians have been described for over 2 decades,[11] but only recently has its indirect sequalae on patients, populations of patients, and the cost of care been appreciated.

Patient care is directly affected by burnout. Medical errors, ICU mortality rates, and longer discharge recovery times are positively correlated with burnout and decrease the patient's experience of care.[12-14] Populations of patients are also indirectly affected. Increased physician turnover, decreased physician work effort, and productivity are positively correlated with burnout,[15-17] which impedes access to care, strains local health care resources, and destabilizes remaining physicians' patient panel sizes.[18] The cost of care is also affected. Increased medical

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orders and referral rates[19] and increased physician turnover are all positively correlated with burnout, which increases health care costs. The decreased physician work effort and productivity, equivalent to the lost productivity of 7 graduating medical school classes,[20] may also transform simple, inexpensive care into delayed, expensive care.

Recent initiatives addressing burnout have been promising. Medical schools now incorporate physician burnout in their curricula, national organizations have wellness initiatives, and medical groups have initiated wellness committees with chief wellness officer positions. Although the prevalence of physician burnout has improved,[21] it remains significantly entrenched in the profession. More innovations are critically needed, as physician burnout affects the Triple Aim specifically at the 3 areas it endeavors to improve.

Of the 3 confounding issues to the Triple Aim, unmeaningful work may be the least understood and its adverse effects on primary care and physician burnout most underappreciated. Any work associated with direct patient care may be meaningful. However, work not license-level appropriate nor clinically relevant to the work at hand may be perceived as unmeaningful. Unmeaningful work could be further defined as cognitive work demanded upon a physician that is not license-level appropriate, adds no value to a clinical encounter, and typically must be completed to finalize that encounter. Further work is needed to refine unmeaningful work's definition and develop its taxonomy. Preliminary subgroups could include miscellaneous unmeaningful work units, electronic frustrations, and redundant layers of complexity.

Several examples of these subgroups could be given, but only a few will suffice to underscore unmeaningful work's subtle pervasiveness in medicine. Unmeaningful work units include the requirement of computerized physician order entries to be completed only by physicians due to the persistent misinterpretation of regulatory statutes associated with them.[22] Electronic frustrations, widespread within the now widely perceived dysfunctional electronic health record (EHR) ecosystem, include the seemingly endless EHR pop-ups intruding into a clinical encounter.[23] Redundant layers of complexity are the added, unnecessary requirements health care entities compel physicians to complete to order to practice medicine within those entities and that supersede a Medical Practice Act's requirements and include discordant continuing medical education and maintenance of certification activities.[24]

Unmeaningful work intrudes upon the cognitive work needed in a clinical encounter, acts as a disrupter to care, and invades the cognitive workspace needed by a physician in that encounter. Recent work evaluating cognitive load in clinical settings has been promising,[25] but further work on how unmeaningful work negatively affects physician well-being is needed. A principle or overarching ethic is also wanting—one that describes the physician's cognitive workspace utilized in a clinical setting and endeavors to safely protect it. Further studies also are needed to evaluate if protecting a physician's cognitive workspace decreases unmeaningful work, decreases physician burnout, and affects the ongoing demise of primary care.

The dysfunctional status of the US health care system persists. Meaningful transformation remains elusive. Several factors confound the Triple Aim, and unmeaningful work is the least understood. Its presence underscores that an ethic is needed to protect physicians and their cognitive workspace within a clinical setting.

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that supports the use of yoga to treat certain medical and psychological conditions. They found that yoga improved both depression and back pain and served to promote overall health and improve mental health.[12] Ward et al found that a structured, culturally adapted class improved depression in a group of African American adults.[13] This study challenges the health care profession to adapt interventions for diverse populations of people.

Finally, as the COVID-19 pandemic has shaken the health care environment to its core, the *WMJ* continues to publish content on clinical and system issues related to this virus, including a papers in this issue regarding COVID management and cultural practices in the Hmong community[14] and more. To access a curated collection of all the papers *WMJ* has published regarding myriad aspects of COVID-19 in Wisconsin, visit our website.

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