COMMUNICATION

IN LIFESTYLE MEDICINE

Salvatore Lacagnina, DO

The Triple Aim Plus More

When it comes to the delivery of health care, we as providers need to be cognizant of many things which do not necessarily have to do with the actual administration of the clinical care but are, nonetheless, just as important. In years past, the Institute for Healthcare Improvement coined the term *Triple Aim*, which describes an approach to optimize health system performance. The focal points are improving *patient experience*, including the *quality of care* and *patient satisfaction*; improving the health of populations; and reducing the per capita cost of health care. In addition to the above, I would include improving the lives of the providers, especially when it relates to the areas of resilience, burnout, and suicide. So let us first look at the patient experience, which often times is not optimal. As health care providers, we have to pay attention to the experience the individuals have when engaging with all parts of the health care system. Access to care is often times the first challenge for a potential patient, and when it comes to outpatient care, the wait times to see a physician or to have tests or procedures completed is certainly too long. Think about how long you (the reader) would want to wait to get an appointment. In certain areas of the country, it might be as long as several weeks to more than 1 month to get an appointment. This alone affects the quality of care because health care is

postponed, and during this time, the condition might worsen. When this happens, the individual might decide to go the emergency room or to a walk-in clinic (urgent care center). For a nonacute illness, going to an ER exposes the individual to (often times) more testing that is unnecessary and, thereby, contributes to unnecessary expense for the patient as well as the company that insures the individual. Also, when unnecessary tests are done,

optimal and the quality of care and the health of the patient suffer.

Quality of care can be defined in several different ways and by different individuals. In the true definition, quality of care relates to clinical outcomes. This means that as a result of an intervention, the person's illness improves and the health of the individual increases. Many national authorities set clinical guidelines related to the quality of the health care delivered. If we use diabetes as an

In addition to the above, I would include improving the lives of the providers, especially when it relates to the areas of resilience, burnout, and suicide.

there is a chance for what is called a “false-positive” result, meaning that the test appears abnormal when the individual does not actually have a problem. When a false-positive result occurs, the patient is subjected to additional tests, procedures, or even surgery to make a definitive diagnosis. With all these interventions, the person can be at risk for harm arising from additional testing, procedures, and medications or even invasive interventions. As a result, the overall experience for the patient is less than

example, the American Diabetes Association sets guidelines for the management of diabetes and focuses on improvements in blood tests related to diabetes, the results of a comprehensive dilated eye examination, kidney function tests, and the results of a neurological examination. If we look at the definition of *quality care* as relayed by the patient, we get an entirely different response. Patients often times relate “getting what they came for” to quality. The person in pain wants to leave the doctor's office with a prescription for a pain killer. The

DOI: 10.1177/1559827618806183. From the Department of Internal Medicine, Lee Health, Florida. Address correspondence to: Salvatore Lacagnina, DO, Department of Internal Medicine, Lee Health, 708 Del Prado Blvd No. 2, Cape Coral, FL 33990; e-mail: salvatore.lacagnina@leehealth.org.

For reprints and permissions queries, please visit SAGE's Web site at www.sagepub.com/journals-permissions

Copyright © 2018 The Author(s)

individual with an upper-respiratory-infection wants to leave the doctor's office with a prescription for an antibiotic even though he/she was told the infection was viral. An individual waiting for an appointment for a number of weeks may relate this as poor quality even though when seen by the physician or other health care provider, the true quality of the care delivered was exceptional. As such, we need to be specific about the definition of quality care and know who is making this determination.

Patient satisfaction (or dissatisfaction) is the result of myriad exposures. A new patient might not be satisfied with the wait time to get in to see the physician. Individuals who are given an emotional diagnosis might not be satisfied with the visit as a result of finding out that they are not as healthy as they initially believed. If the bill for the service was expensive, patient satisfaction suffers.

For many years, physicians have been compensated based on the time they spend with a patient, which is what is referred to as "fee for service." In recent years, there has been a shift in the perspective related to compensation and the term *value-based care* has emerged. This relates to the value of the health care delivered, which basically relates to whether or not the person is getting healthier. This concept is interesting because the results of a clinical intervention have to do with several issues that include, but are not limited to, the physician prescribing the correct treatment, the patient being compliant with the recommended treatment, the severity of the illness at the time the intervention is prescribed, other comorbidities the patient has at the time of the new intervention, and myriad other things that influence the outcome. If the patient does not have the money to purchase the prescribed medication, and he/she does not give the physician this information, the outcome is negatively affected and the physician does not understand why (and might even prescribe more medication!)

The cost of health care in the United States is another tremendous problem

because health care is so expensive, but unfortunately, the outcomes as compared to other countries are not what we would expect. That is to say, the return on the investment is not optimal. In other developed countries, the clinical outcomes are higher, and in many, the cost of health care is not as expensive as it is in the United States. There are many reasons cited for this discrepancy, including the cost of technology, the cost of developing blockbuster pharmaceuticals, the medical legal system, and the fact that health care services are often times overprescribed. If a person goes to an emergency room for an illness that probably could have been handled in an urgent care center, the bill will be significantly higher, with the outcome often times no better. Also, as mentioned above, in the emergency room, more tests might be done adding to the expense and the risk of false-positive clinical results. Certainly, the cost of health care in the United States results in patient dissatisfaction, complaints, and noncompliance, and often, individuals wait too long before they seek medical attention. And when the patient is not happy, neither will be the physician or health care provider.

Physician satisfaction is a significant concern in the world of health care today. Anecdotally, I have heard many physicians say that they would never encourage their children to go to medical school. This statement is disheartening because I believe that being a physician is an honor and a privilege. This is a noble profession, and the work lends itself to physicians having a significant impact on the individuals and community they serve. The more concerning problem comes in when we look at physician resilience and burnout. When it comes to resilience, we know that it is becoming more difficult for physicians and other health care providers to "bounce back." In the current climate, a typical primary care physician has to see another patient every 15 to 20 minutes. Personally, I did this for 18 years, and taking care of those who have multiple medical problems and are on many different medications lends itself to an

extremely challenging week. It is very hard to keep up with this pace, and if the physician is also seeing patients in the hospital, he/she has a 12- to 14-hour day and may also be up during the night seeing another patient in the emergency room. As a result of this constant stress, many physicians burn out and are even at risk for suicide. Research has shown that the suicide rate for physicians is very high, with an average age around 56 years. So this is the reason health systems have to take care of patients but also need to take care of the health care providers. Health systems should be encouraged to provide stress management products and services and should be screening individuals for depression, suicidal tendencies, drug and alcohol overuse and abuse, insomnia, and other mental health disorders.

So we can see that the original "Triple Aim" should be expanded to include several other initiatives in order to have a health care system that intentionally takes care of the patients as well as the health care providers. Only by focusing on each party can we truly have a health care system with optimal clinical and financial results.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Informed Consent

Not applicable, because this article does not contain any studies with human or animal subjects.

Trial Registration

Not applicable, because this article does not contain any clinical trials. **AJLM**