



care centered  
collaborative™

*Patient-centered. Physician-led.*



Embracing Patient Care Data  
Improving Outcomes

\*and\*

Your Bottom Line

*(or...Using Data & MACRA for Fun & Profit)*

Jaan Sidorov MD

Care Centered Collaborative at the  
Pennsylvania Medical Society



## Using Data for Fun and Profit

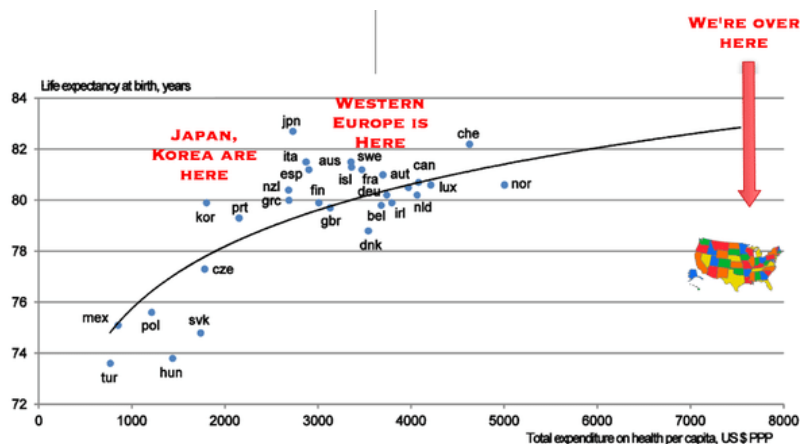
Describe the:

- limits of “value-based” care in the U.S.
- barriers to measuring quality
- role of physician leadership in microsystems
- responses to insurer meddling
- resources required to collect, analyze and act on quality measurement
- impacts of MACRA




First of all.....

## Healthcare Value i.e. **Outcome/Cost**



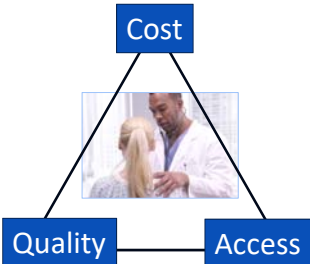
## Why U.S. Healthcare Value Ain't That Bad

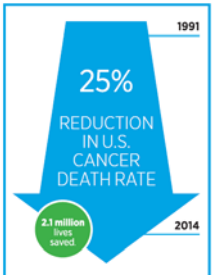



### 1. The "Iron Triangle"

*"Two Out of Three": Access vs. Cost vs. Quality*

AACR CANCER PROGRESS REPORT 2017







## Why U.S. Healthcare Value Ain't That Bad



### 2. U.S. Cost Trends Are In Line with Global Patterns

Average annual growth in health spending across OECD countries in real terms, 2000-2011



**Legend:** 2000-09 (light blue), 2009-11 (dark blue)

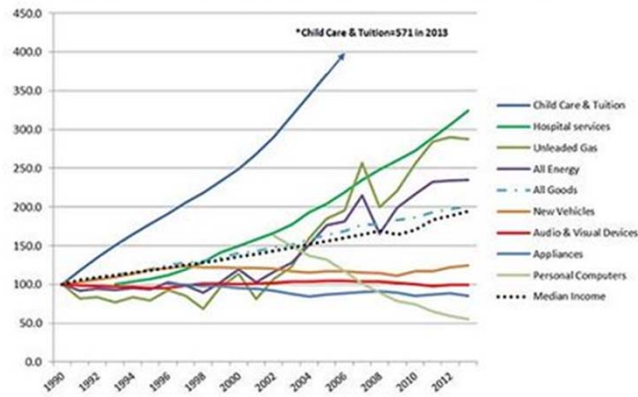
**Notes:**  
 Growth rates for Australia, Denmark, Japan, Mexico and Slovak Republic refer to 2000-10 instead of 2000-11  
 Growth rates for 2009-11 are not available for Luxembourg, and Turkey  
 Growth rates for China calculated using the Consumer Price Index (CPI)



## Why U.S. Healthcare Value Ain't That Bad

### 3. "Cost Disease" Numerator/Denominator

Median Income and Change in Price of Select Goods 1990-2013 (1990=100)

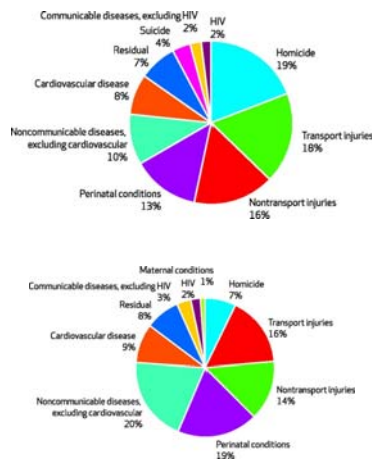


BROOKINGS

## Why U.S. Healthcare Value Ain't That Bad

### 4. Social Determinants of Health (or "SDH")

Contribution Of Cause-Of-Death Categories  
Years Of Life Lost Below Age 50 Between The United States vs. Other Countries.



1) Mortality differences below age 50 account for **two-thirds of the gap in life expectancy** between American males vs. other countries. Among females, the figure is **two-fifths**.

2) The major causes of death responsible for the below-fifty trends **unintentional injuries, including drug overdose, noncommunicable diseases and homicide**.

3) In all, this study highlights the importance of focusing on younger ages and on policies both to prevent the major causes of death below age fifty and to **reduce social inequalities**

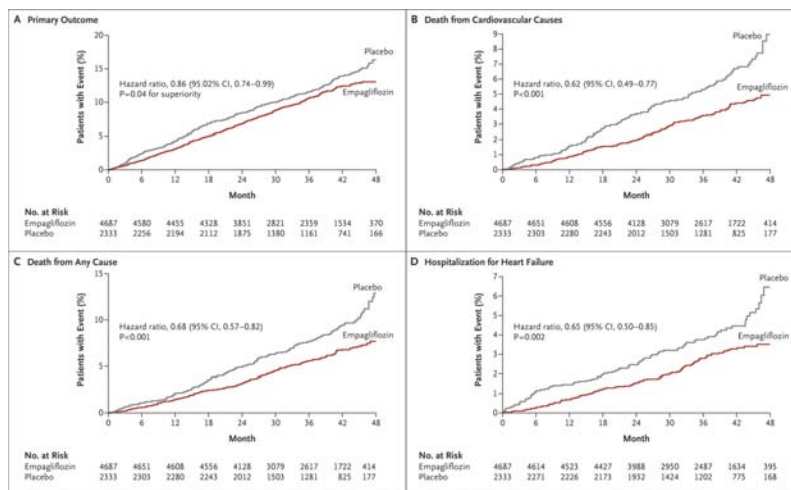
Jessica Y. Ho Health Aff 2013;32:459-467



## But What About Quality?



## Impacts can be significant...





## ...but are more often modest...

PMC full text: [J Med Internet Res. 2015 Apr; 17\(4\): e92.](#)  
 Published online 2015 Apr 10. doi: [10.2196/jmir.4052](#)  
[Copyright/License](#) ▶ [Request permission to reuse](#)

**Table 3**

Changes in body weight and A1c of participants over time.

	Starters (4+ lessons)			Completers (9+ lessons)				
	Weight loss, % change (SE) <sup>a</sup>	P value	A1c, change (SE) <sup>a</sup>	P value	Weight loss, % change (SE) <sup>a</sup>	P value	A1c, change (SE) <sup>a</sup>	P value
16 weeks-Baseline	5.0 (0.3)	<.001	0.03 (0.06)	.55	5.2 (0.3)	<.001	0.03 (0.06)	.62
Year 1-Baseline	4.7 (0.4)	<.001	-0.38 (0.07)	<.001	4.9 (0.5)	<.001	-0.40 (0.07)	<.001
Year 2-Baseline	4.2 (0.8)	<.001	-0.43 (0.08)	<.001	4.3 (0.8)	<.001	-0.46 (0.08)	<.001
Year 2-Year 1	-0.5 (-0.4)	.25	-0.06 (0.07)	.39	-0.5 (-0.5)	.20	-0.06 (0.07)	.38

<sup>a</sup>Adjusted means from linear mixed models.

## And often don't reduce costs

21 peer reviewed articles examining the association between integration, cost and quality  
 Am J Manag Care 2013;19(5):e175-e184

■ REVIEW ARTICLE ■

### Effects of Integrated Delivery System on Cost and Quality

**But....higher quality – even if modest can be achieved  
at the same cost**

and Harold Paz, MD, MS

“The vast majority of studies we reviewed have shown that integrated delivery systems have positive effects on quality of care. Few studies linked use of an integrated delivery system to lower health service utilization. Only one study reported some small cost savings.”





## 3 Minutes



What is the biggest barrier to assessing quality?



## Other Barriers?

- Disconnected from the real world....
- Threats to professional autonomy...
- Tool to penalize bad apples
- Lack of time....
- Lack of money....
- *Pursuing* quality measures are a function of knowledge, persuasion and decision....
- *Using* insights is a function of attitudes, beliefs and values.

Addington: Facilitators and barriers to implementing quality measurement *Can Fam Physician* 2010;56(12):1322  
Schuster M: Measuring the cost of quality measurement. *JAMA* 2017;318:1219



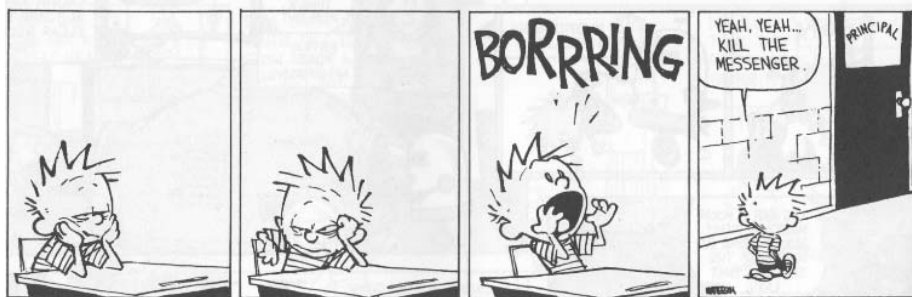
## Other Barriers

### Process Measures

1. Don't always lead to desired outcomes
2. Aren't always captured
3. Rarely are a single link to an outcome
4. Can lead to unintended consequences

### Outcome Measures

1. Not always linked to medical care
2. Not always measurable
3. Not risk adjusted
4. Can lead to unintended consequences





## Physician Support for MACRA?



Drew et al: Provider perspectives on APMs. *Pop Health Manag* Jan. 2017  
 N=242 with an interest in population health.  
 Likert 1 (strongly disagree) - 5 (strongly agree)

### Under Alternative Payment Models.....

Domain	Overall	Health System Leader	Physician Leader	Non-leader Physician	P value
... changes in my practice/system have hindered its ability to provide high-quality care.	3.00 (1.19)	2.61 (1.05)	3.16 (1.26)	<b>3.27</b> (1.12)	P<.05
... I feel more professionally satisfied.	2.69 (1.13)	3.11 (0.89)	2.46 (1.23)	<b>2.54</b> (1.10)	P<.05
... my practice/system has hired new staff to manage patients effectively	3.41 (1.39)	4.05 (1.14)	3.20 (1.39)	<b>2.83</b> (1.40)	0.001
Attitudes Toward Alternative Payment Models (AAPM) Scale	3.05 (0.52)	3.28 (0.42)	2.91 (0.57)	<b>2.95</b> (0.47)	0.003

<http://online.liebertpub.com/doi/full/10.1089/pop.2016.0128>



## Local Physician Leadership “Clinical Microsystems”



- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Collective goals &amp; actions at the work unit</li> <li>2. Evidence-based vs. patient centered care</li> <li>3. Monitor performance</li> <li>4. Improve performance</li> </ol> | <p>Contrary to teaming<br/>No....</p> <ul style="list-style-type: none"> <li>• formal authority</li> <li>• protected time</li> <li>• training</li> <li>• mentorship</li> <li>• institutional support</li> </ul> |
|---|---|

Bohmer RMJ: Leading clinicians and clinicians leading. NEJM 2013;368:1468

## Local Physician Leadership The “SPAM-R” Approach to Measurement



- Is it *Simple*?
- Can it be *Piloted* (and changed)?
- Will it be *Accepted* (and is locally relevant)?
- Is there *Merit*? (buy in)?
- If so, will the *Resources* be Committed?

Berwick: Disseminating innovations in healthcare. JAMA 2003;289(15):1969



## Insurer Meddling?

Inaccurate lists

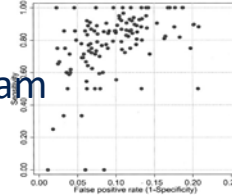
- Yes, and all tests have false positives/negatives

Alert Fatigue

- Yes, and you can outsource to team
  - *Substitutive, not Additive* work
- “Not my patient!”

- there’s no doc-patient *relationship*

Lacks Scientific Excellence.....



Barlow W E et al. JNCI J Natl Cancer Inst 2004;96:1840-1850



## Scientific Evidence

### *The TIRESOME ENGLAND JOURNAL of MEDICINE*

ESTABLISHED IN 1812      JULY 26, 2017      VOL. 367 NO. 4

#### Less-Than-Pristine Data Analytics Associated with the Premature Death of Kittens in Pennsylvania.

Dawn Believit, M.D., M.P.H., Max Bias, M.D., M.P.H., Dresden Blinders, Ph.D., Ivory Tower, M.D., Mind Madeup, M.D., Wanda Morestats, M.D., M.P.H., Jimmy DaNumbers, M.D., Cantu Proveit, M.D., M.P.H., Ima Academe, M.D., Tzume Enkissmybutt, M.D., M.P.H., Shant Lookagain, M.D., Fetch Moredata, M.D., Vera Skeptical, M.D., Ima Peacock, M.D., for the PREORDAINED-II Investigators

#### ABSTRACT

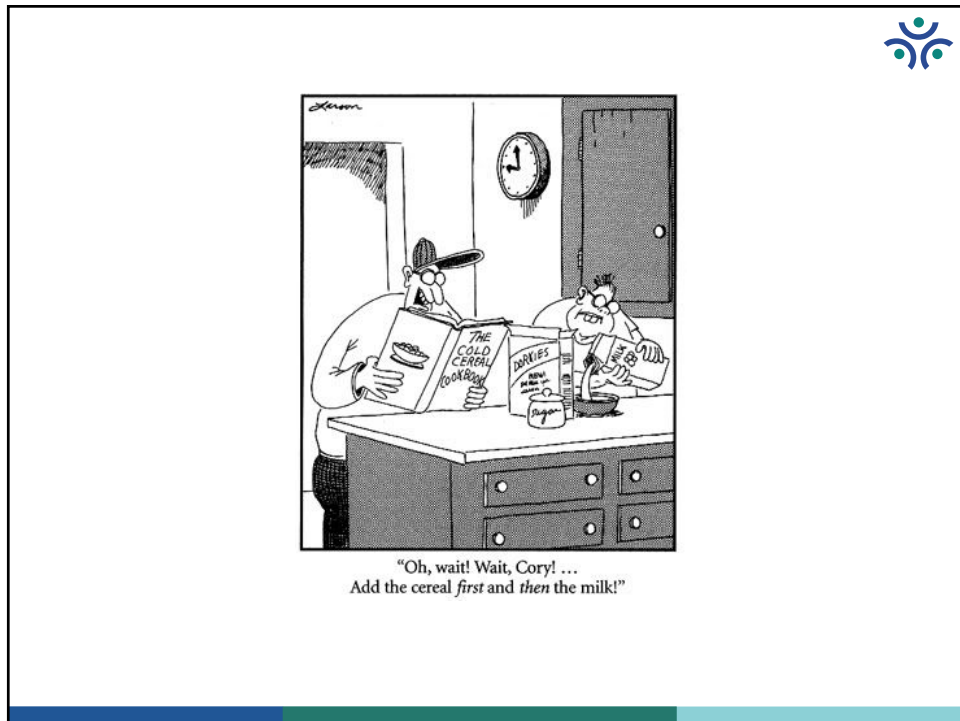
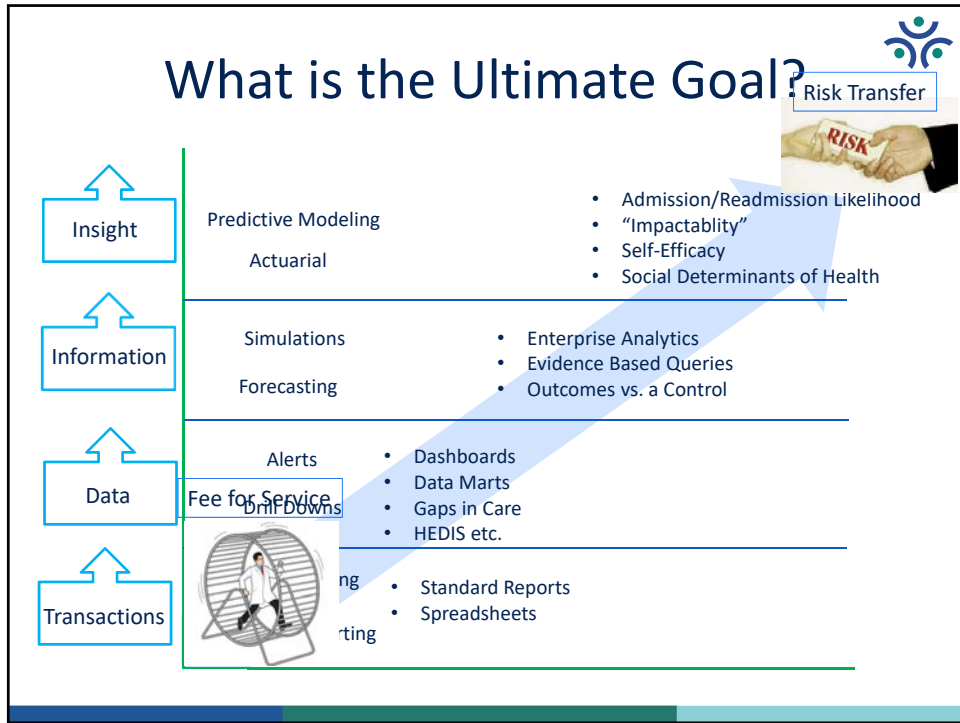
##### BACKGROUND

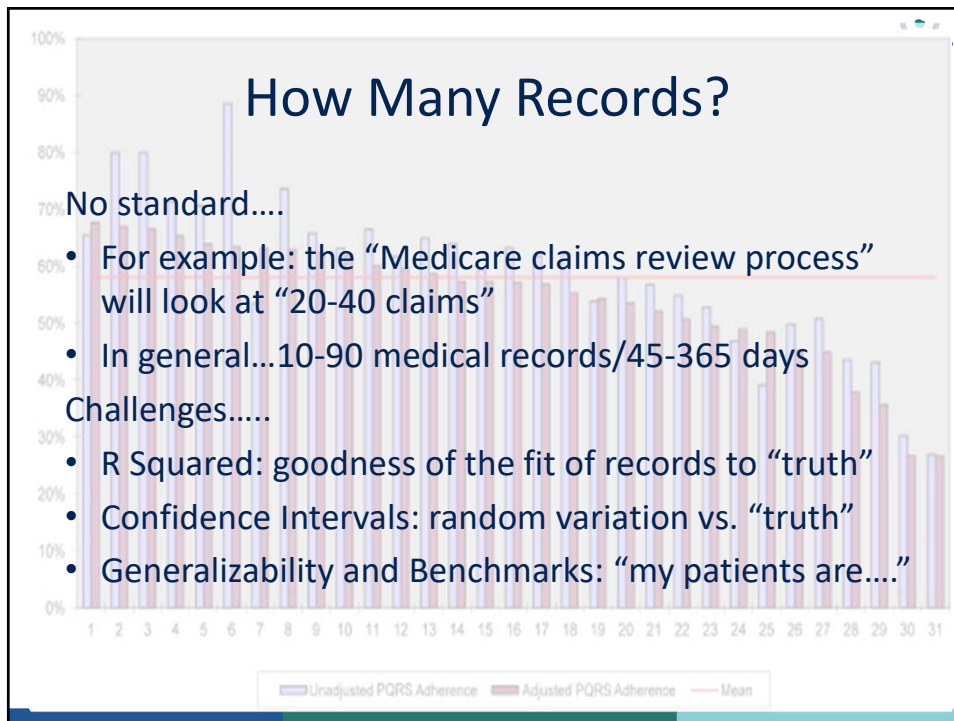
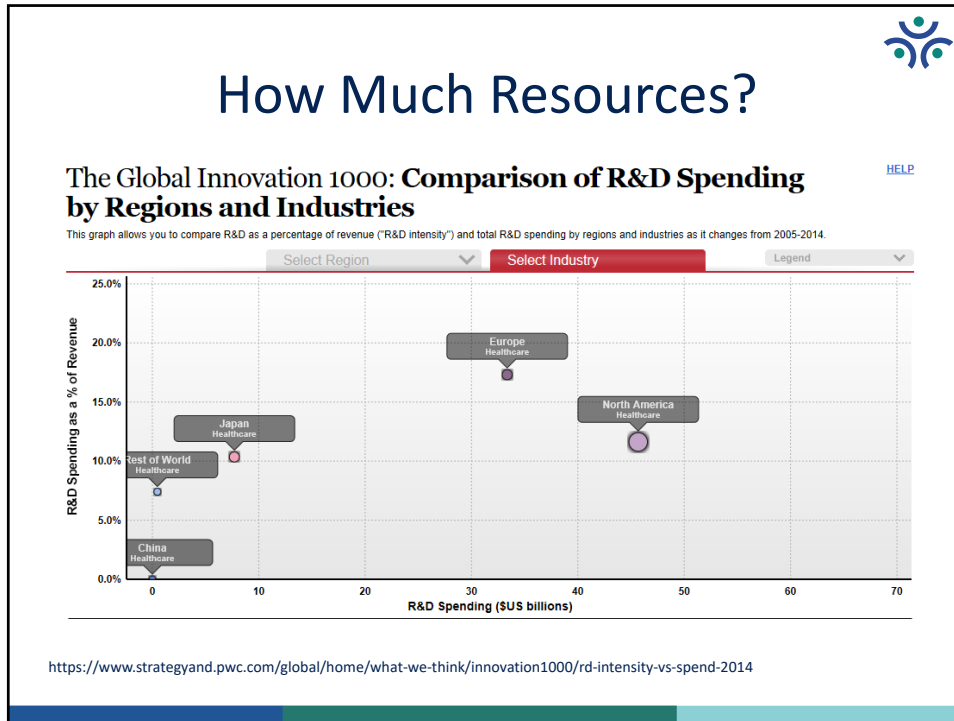
It is unclear if physician-led investigation of local outcomes is ineffective or evil in the care of outpatients. Some studies suggest this approach leads to an inordinately high rate of baby feline expirations.

##### METHODS

In this study, we non-randomly selected studies from journals only we read and performed an analysis of the data using criteria that have no meaning to anyone who actually takes care of patients in the real world. We assigned ourselves to looking at the studies and when we were done, we made sure our impression fit a preordained conclusion.

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Believit at Massachusetts Monopoly Hospital, Whip the Numbers Department, 185 Biased St, Boston, MA 02114. T: Engl J Med 2012;367:13,955-309. DOI: 10.5888/TEJ.Moa000012938 10293/ Copyright © 2012 Disease/Management/Care/Boo







## Hawthorne Effect

- Often unconscious behavioral changes due to an awareness of being observed, plus
- Compliance with the wishes of the observers



## Directionality

A (clinical) tide raises all (measurement) boats

Direct.... and Indirect.

“Cervical Cancer Screening”

- Denominator: all women 21-64 years of age
- Numerator: screened every 3 years

“Mammogram Reminders”

- Denominator: all patients with a mammogram
- Numerator: entered into a reminder system

The results will vary by payor, clinic or analyst,  
but ALL should improve over baseline.



## Then What? Patient Enrollment



- Recruitment that uses incentives, is culturally appropriate via multiple channels, including mail, telephony and social media.
- Data are stored in Registries: multi-sourced repositories of formatted data
  - Easy extraction and manipulation of individual or grouped information including demographic, insurance claims, survey, clinical and other data.
- *Challenges:* recruitment rates typically run 5-15% thanks to limited patient incentives and lack of physician buy-in, time and compensation of work effort.



## Then What? Education/Intervention



- **Old:** print materials, one-on-one face-to-face and telephonic instruction
- **New:** education that leverages behavior change using psychological principles of recruitment, engagement, assessment of barriers, formulation of strategies to overcome barriers, goal setting, coaching, support and follow-up.
- Includes “texting,” variations of email and social media such as Facebook.
- *Challenges:* disconnected from the electronic health record and physician input

## Then What? Non-Physician Involvement



- Collaborative assessment, planning, facilitation and advocacy for care options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes
- Provides education, promotes informed decision making, develops a care plan that coordinates insurance benefit designs, psychosocial issues, input of family, community resources and the physicians' judgment.
- Associated with greater frequency of self care, control of lifestyle behaviors, problem solving, medication compliance and improved outcomes
  - Facilitate patient enrollment
  - Advocate on behalf of the intelligent adoption of guidelines
  - Collaborate & Integrate providers

## 3 Minutes



What Quality Measures are your Best Opportunity?





**MACRA**

“Hello doctor, I’m from the government and I’m here to help”

Quality Payment Program    Learn About the Program    Explore Measures    Education & Tools

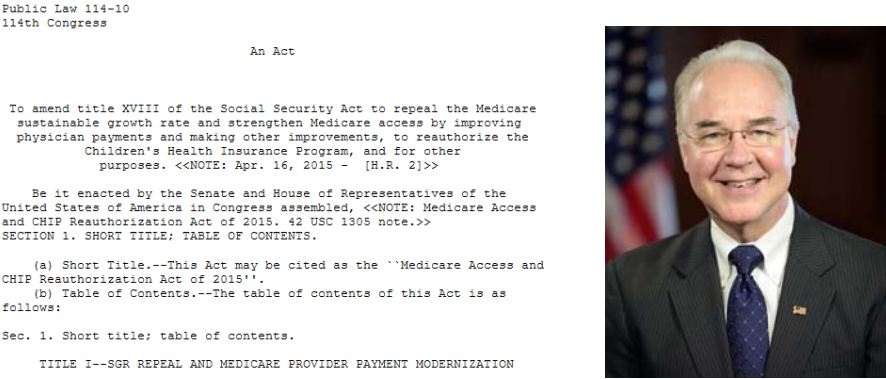
Avoid the “fiscal cliff” of the SGR

“Streamline” quality measures

**Quality Payment Program**

“Making patients healthier”

modernizing Medicare to provide better care and smarter spending for a healthier America.



Public Law 114-10  
114th Congress

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes. <<NOTE: Apr. 16, 2015 - [H.R. 2]>>


Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, <<NOTE: Medicare Access and CHIP Reauthorization Act of 2015. 42 USC 1305 note.>>  
SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.--This Act may be cited as the ‘‘Medicare Access and CHIP Reauthorization Act of 2015’’.

(b) Table of Contents.--The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I--SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION



Passed the House on March 26, 2015 (392–37)  
Passed the Senate on April 14, 2015 (92–8)  
Signed into law by President Barack Obama on April 16, 2015



January 25, 2017

The Honorable Donald J. Trump  
 President of the United States  
 The White House  
 1600 Pennsylvania Avenue, N.W.  
 Washington, D.C. 20500

The Honorable Michael R. Pence  
 Vice President of the United States  
 The White House  
 1600 Pennsylvania Avenue, N.W.  
 Washington, D.C. 20500

Dear Mr. President and Mr. Vice President:

On behalf of the nation's leading clinicians, employers, hospitals, biopharmaceutical companies, pharmacists, patients, consumer groups and insurance providers, we are writing to underscore our commitment to advancing the highest quality, most cost-effective healthcare system in the world. We call upon Congress and the Trump Administration to help us achieve this goal.

This work has been spurred by nearly two decades of bipartisan leadership and was most recently accelerated by this Congress' overwhelming passage of the Medicare Access and CHIP Reauthorization Act (MACRA). Through private and public sector alignment, the move toward value-based care is succeeding, measurably improving healthcare quality and contributing to historically low costs. Now is not the time for policymakers to signal a shift away from value-based care, either through action or inaction.

We, the undersigned, strongly support this movement and are committed to working with Congress and the Trump Administration to build the next generation of healthcare policy. As you take up the mantle of addressing the challenge of improving quality while safely reducing costs, we strongly urge you to continue focusing on driving value-based, patient-centered payment models that incent healthcare innovation. Together, we share a vision for a modernized,

## Linking Dollars to Quality



MIPS Performance Years, Payment Years and Adjustments, and Category Weighting						
Performance Year	Payment Year	Payment Adjustments	MIPS Category Weighting			
			Quality	Cost	ACI	CPIA
2017	2019	+/- 4%	60%	0%	25%	15%
2018	2020	+/- 5%	50%	10%	25%	15%
2019	2021	+/- 7%	30%	30%	25%	15%
2020	2022	+/- 9%	30%	30%	25%	15%

**Quality:** Report at least six quality measures: 60 points

**ACI and CPIA** are based on "Attestation"

*ACI:* Protecting PHI, ePrescribing, health information exchange etc.....

*CPIA:* Full credit for NCCQA, URAC or other Patient Centered Medical Home (PCMH); there are other improvement activities....



## MACRA Pushes Payers to Adopt Value-Based Care Payment Models

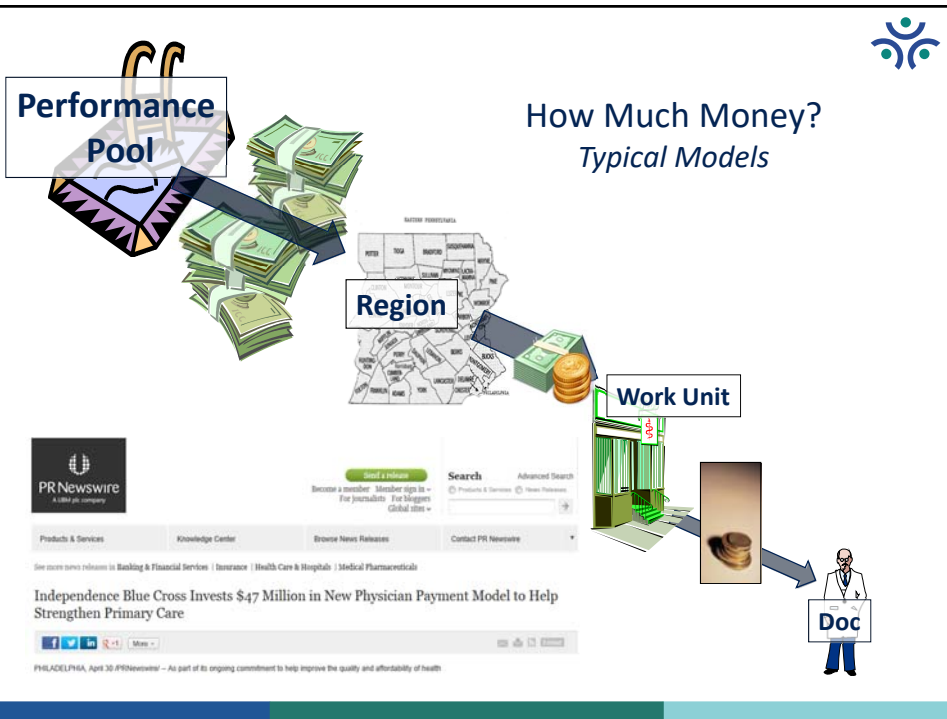
With providers focused on meeting MACRA regulations, commercial payers are investing in value-based care payment models that align with the quality payment program.



**And here come the other payers....**  
*“The main issue is to make more models available to providers since many are eager to enter these type of programs and are looking for partnerships with payers.”*

Performance Pool

How Much Money?  
Typical Models





# Not This Time....

## Estimated Annual Physician Financial Impact

Using industry data, it is possible to estimate the potential net impact of the APM and MIPS payment models to a physician

### Estimated Annual Financial Impact by Physician Type:

Physician Practice Area	Revenue & Payer Mix			Annual Financial Impact (2019)			
	Total FFS Rev.	% Medicare	Medicare FFS Rev.	APM (+5%)	MIPS (+4%)	MIPS (-0%)	MIPS (-4%)
Primary Care	\$545,573.00	24.37%	\$132,956.14	\$6,647.81	\$5,318.25	\$ -	\$(5,318.25)
Non-Surgical Specialist	\$534,131.00	40.44%	\$216,002.58	\$10,800.13	\$8,640.10	\$ -	\$(8,640.10)
Surgical Specialist	\$884,596.00	35.39%	\$242,278.52	\$12,113.93	\$9,691.14	\$ -	\$(9,691.14)

### Potential APM Bonuses vs. Potential MIPS Payment Adjustments (2019-2024)

	2019		2020		2021		2022		2023		2024	
	APMs +5%	MIPS +/-4%	APMs +5%	MIPS +/-5%	APMs +5%	MIPS +/-7%	APMs +5%	MIPS +/-5%	APMs +5%	MIPS +/-5%	APMs +5%	MIPS +/-9%
Primary Care Physician	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-
	\$6,648	\$5,318	\$6,648	\$6,648	\$6,648	\$9,307	\$6,648	\$11,966	\$6,648	\$11,966	\$6,648	\$11,966
Non-Surgical Specialist	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-
	\$10,800	\$8,640	\$10,800	\$10,800	\$10,800	\$15,120	\$10,800	\$19,440	\$10,800	\$19,440	\$10,800	\$19,440
Surgical Specialist	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-	+	+/-
	\$12,114	\$9,691	\$12,114	\$12,114	\$12,114	\$16,960	\$12,114	\$21,805	\$12,114	\$21,805	\$12,114	\$21,805

Source: MGMA 2014 Reports

17 Deloitte Advisory Regulatory Services for Life Sciences and Health Care

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# Even worse....

## MIPS/MACRA FUTURE FINANCIAL EFFECT ON PHYSICIAN PRACTICES MEDICAL AND DRUG SERVICES 2019-2022

PROVIDER TYPE	Avg. Medicare Allowed Amount Per Physician for Medical Services	Medical Services			Avg. Medicare Allowed Amount Per Physician for Drug Services	Drug Services			Combined Medical and Drug Services		
		Total 4 year Cumulative Potential Incentive	Total 4 year Cumulative Potential Loss	Total 4 year Cumulative Potential +/- Revenue Swing		Total 4 year Cumulative Potential Incentive	Total 4 year Cumulative Potential Loss	Total 4 year Cumulative Potential +/- Revenue Swing	Total 4 year Cumulative Potential Incentive	Total 4 year Cumulative Potential Loss	Total 4 year Cumulative Potential +/- Revenue Swing
Hematology/Oncology	\$225,379	\$56,345	\$56,345	\$112,690	\$583,237	\$145,809	\$145,809	\$291,619	\$202,154	\$202,154	\$404,308
Medical Oncology	\$181,747	\$45,437	\$45,437	\$90,874	\$473,926	\$118,482	\$118,482	\$236,963	\$163,918	\$163,918	\$327,837
Ophthalmology	\$326,621	\$81,655	\$81,655	\$163,311	\$166,745	\$41,686	\$41,686	\$83,373	\$123,342	\$123,342	\$246,683
Rheumatology	\$156,839	\$39,210	\$39,210	\$78,420	\$208,011	\$74,503	\$74,503	\$149,006	\$113,713	\$113,713	\$227,425
Radiation Oncology	\$403,512	\$100,878	\$100,878	\$201,756	\$4,687	\$1,172	\$1,172	\$2,344	\$102,050	\$102,050	\$204,100
Hematology	\$128,187	\$32,047	\$32,047	\$64,094	\$265,011	\$66,253	\$66,253	\$132,506	\$98,300	\$98,300	\$196,599
Dermatology	\$331,108	\$82,777	\$82,777	\$165,554	\$2,937	\$734	\$734	\$1,469	\$83,511	\$83,511	\$167,023
Vascular Surgery	\$329,874	\$82,469	\$82,469	\$164,937	\$206	\$52	\$52	\$103	\$82,520	\$82,520	\$165,040
Interventional Pain Mgmt	\$313,547	\$78,387	\$78,387	\$156,774	\$8,335	\$2,084	\$2,084	\$4,168	\$80,471	\$80,471	\$160,941
Cardiology	\$296,129	\$74,032	\$74,032	\$148,065	\$7,062	\$1,766	\$1,766	\$3,531	\$75,798	\$75,798	\$151,596

Medicare Part B Billings taken from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-01-2.html>

Yearly reductions taken from: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-lan-ppt.pdf>



## Some MACRA Upsides?



### Upsides



Patients:  
higher quality,  
same price

Physicians  
Recognized for quality

## A MACRA MIPS Dashboard Example



**Quality Measure Advisor**

Select Year: 2017 | Select a Specialty Measure Set: All Specialties | Select Reporting Method: Registry

#	Measure Name	Outcome	High Priority	Strata	Documents	Performance	Ease of Extraction
1	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	✓	✓	1	Spec	Performance	★★★★★
5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Rec...			2	Spec	Performance	★★★
6	Coronary Artery Disease (CAD): Antiplatelet Therapy			1	Spec	Performance	★★★★★
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) ...			2	Spec	Performance	★★
8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)			2	Spec	Performance	★★
12	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation			1	Spec	Performance	★★★★★
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination			1	Spec	Performance	★★★★★
19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes...	✓		1	Spec	Performance	★★
21	Preoperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation C...	✓		1	Spec	Performance	★★★★★

QUALITY: 36 of 60

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## A MACRA MIPS Dashboard Example



**Welcome**

Mingle Analytics is here to help you succeed and earn incentives under the new Quality Payment Program. MIPS Solutions™ is your one-stop solution for reporting all three Performance Categories, Quality, Advancing Care Information (ACI) and Improvement Activities (IA).

MIPS Solutions provides a step-by-step process for each performance category in the corresponding module. This MIPS Dashboard and Scorecard page will display your estimated Final Scores and track your progress toward submission to Medicare.

**FINAL SCORE**  
69.1 of 100 (average)

**SUMMARY**  
Practices: 12  
Highest: 93  
Lowest: 4  
Completed: 5

Not Started | Done

Quality Progress | ACI Progress | IA Progress

Employee | Practice 1 | Practice 4 | Practice 10 | Practice 12 | Practice 5 | Practice 11 | Practice 2 | Practice 3 | Practice 7 | Practice 13 | Practice 8 | Practice 14 | Practice 9 | Practice 6

0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100

Exceptional Performance Zone

74 | 81 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93

4 | 14 | 23 | 37 | 44 | 48 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93

74 | 81 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93

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## A MACRA MIPS Dashboard Example



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## Our Triple Aim Pledge

Costs, and... Outcomes...

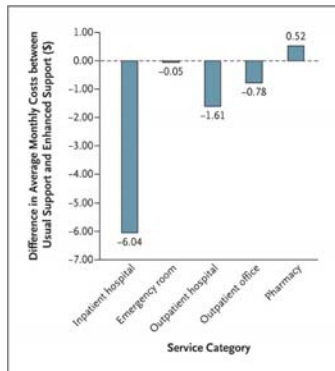
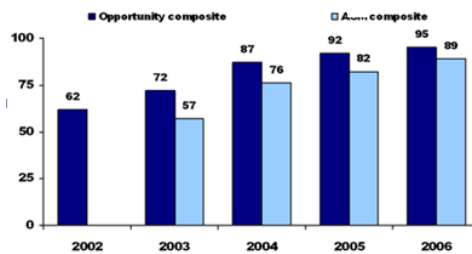


Figure 1. Performance on Heart Failure Quality Measures



# Make that our Quadruple Aim Pledge



**REFLECTION**

**From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider**

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**ABSTRACT**

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely recognized as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus impedes the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

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**INTRODUCTION**

Since Don Berwick and colleagues introduced health care lessons, the concept has spread to other care systems. The Triple Aim is an approach to system performance, proposing that health care improve 3 dimensions of performance: improving the patient experience of care, and reducing costs. The primary Triple Aim goal is to enhance the patient experience of care, and reduce the population, with 2 secondary goals—improving outcomes and reducing costs—contributing to the achievement of the primary goal.

In visiting primary care practices around the United States, we repeatedly heard statements such as, “We use the Triple Aim as our framework, but the stressful work life of staff impacts our ability to achieve the 3 aims.” These sentiments made us wonder, might there be a fourth aim—improving the work life of health care clinicians and staff—that, like the patient experience and cost reduction aims, must be achieved in order to succeed in improving population health? Should the Triple Aim become the Quadruple Aim?

**RIISING EXPECTATIONS OF PHYSICIANS AND PRACTICES**

Society expects more and more of physicians and practices, particularly in primary care. Patients want their health to be better, to be seen in a timely fashion with empathy, and to enjoy a continuous relationship with a high-quality clinician whom they choose.<sup>1</sup> A patient-centered practice has been described as, “They give me exactly the help I need and want exactly when I need and want it.”<sup>2</sup> Yet for primary care, society has not provided the resources to meet these lofty benchmarks.

**PHYSICIAN BURNOUT**

The wide gap between societal expectations and professional reality has set the stage for 48% of US physicians to experience symptoms of

... a fourth aim: improving the work life of healthcare clinicians...

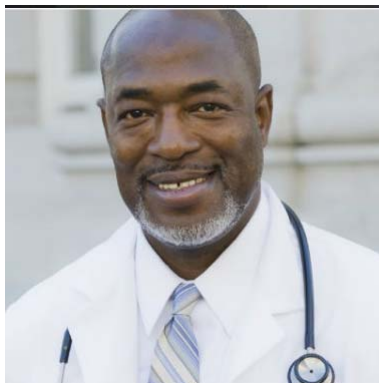
Conflict of interest: author reports none.

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## In Conclusion



- “Administrative Time”
- Substitutive Work
- One OA assigned part time to patient record reviews
- 0.5 day/week for summary data reviews and enrollment updates
- Overhead flexed to value-based payments





## Using Data for Fun and Profit

Describe the:

- limits to “value-based” care
- barriers to measuring quality
- role of physician leadership in microsystems
- responses to insurer meddling
- resources required to collect, analyze and act on quality measurement
- impacts of MACRA