

## Hawai'i Health Partners News

June 2016

### Combating Physician Burnout with Primary Care Redesign and Team-Based Care

Physician burnout is not a new phenomenon. Being a physician takes a special person – typically someone who wants to care for people, is intelligent and willing to take responsibility. It is a high-stakes job. Expectations are high, and the consequences of being wrong are great. There's stress in wanting to give the right treatment and not wanting to miss anything – and malpractice fears only add to it.

The business pressures to succeed have been significant for a while now. If you're employed, this can show up as a schedule overloaded with patients or expanded panels. If you're part of an independent practice, it's the pressure to generate enough revenue to cover the overhead and the hope that your billing and collecting will get you the money you deserve and need – and that your codes are good enough to get paid, not rejected or delayed, and not so good that you get audited, fined or even prosecuted.

The pressures are real and that's BEFORE the high cost of health care drove purchasers and insurers to take increasingly complex, aggressive actions to drive costs down. The requirements to understand the business side of medicine are growing quickly, yet the reason most physicians went to school was to learn how to take care of patients.

Hence, it's understandable that burnout is a threat to physicians. But none of that is new, and many of these things are beyond our control. So, why the increased focus on physician burnout? The evolving health care environment plays a key role.

These days, there is great uncertainty about the future of health care; we are introduced to one new concept after another. New, unfamiliar acronyms are added every day – symbolic of a loss of control for physicians. An increased focus on documentation, technology, business and administrative concerns – particularly all the performance measures – have greatly changed the daily practice of medicine. Incomes are likely to lose pace against inflation, as cost-control efforts take hold, while the cost of living and housing increase. Patient volumes have increased, along with the complexity of patients. Furthermore, patients come in now expecting immediate access and immediate results, sometimes with misinformation.

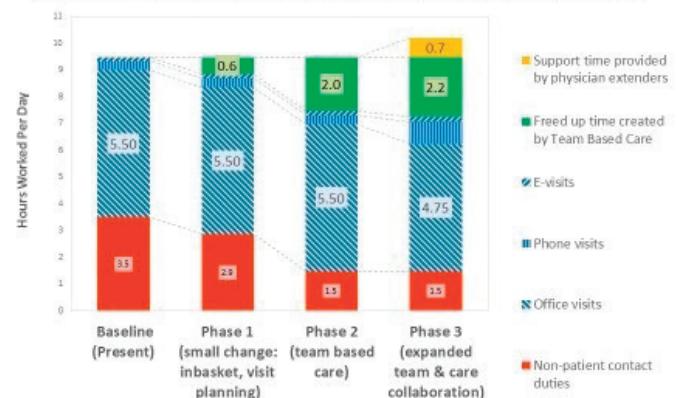
In addition, EHRs add a whole other layer of cognitive overload: too many decisions, too many clicks and "virtual workflows" that don't always line up with the actual workflow of caring for and/or building a good relationship with the patient. Every scrap of information seems to flow to the physician, and since it's time-stamped and lives forever, it's also a potential medicolegal exposure. The stakes are higher.

So, what can be done to change this? Our new efforts around Primary Care Redesign are a major step in the right direction. This project will help, redistribute work across an expanded care team, improve EHR workflows and office efficiencies, and activate patients. . .

### Making the Case for Team-based Care

The goals of our new Primary Care Redesign (PCR) project are to revitalize the intrinsic reward of practicing medicine, while improving population health and reducing the cost of care for the patients we serve. Our physicians will lead the creation of an improved primary care delivery system that allows staff to work at their highest capability, motivates patients to the highest levels of self-care, supports a sustainable and rewarding work environment, and meets our performance goals.

### Team-Based, Primary Care Design Decreases Admin Time and Increases Patient Care Time



Our main objectives include:

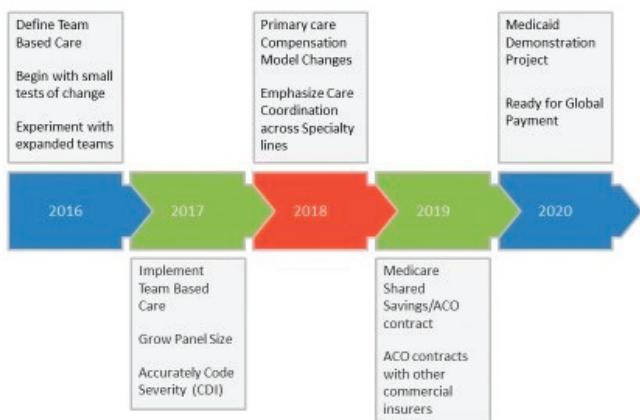
- Reduce the burden of practice. Increase patient experience to the 90th percentile.
- Improve quality outcomes to the 90th percentile.
- Reduce total cost of care by reducing ED use, hospital admissions and readmissions.

- Create a sustainable model for independent and employed physicians, while preparing for primary care payment transformation.
- Grow panel size as appropriate to the expanded care team.

The first phase of the PCR project was completed over the past several months. It focused on enlisting active participation from the clinic chiefs and medical directors, as well as a small group of employed and independent PCPs willing to engage in two tests of change aimed at improving inbox efficiencies and previsit planning.

The second phase of the project is currently underway, with the first wave involving the pilot group and two small tests of change. The second wave will add an additional 25 practices, and a larger third wave will target approximately 80 more practices – all working on these two small tests of change.

## Timeline



The third wave of our PCR project also will focus on larger changes, addressing:

- Team composition and defined roles
- Best practices from current pilots
- Cost structure
- Deployment model for team-based care
- Data infrastructure and measure of success

The PCR work we do will serve as a baseline for our specialist-focused efforts. Stay tuned for regular updates on these projects and lessons learned along the way.

There's a lot of work to be done, but together, we can redefine patient care and the health care environment as we know it. By a thoughtful, proactive redesign of care processes, we can take advantage of changes in payment models to help restore the intrinsic reward of practicing medicine and reduce burnout. The health of our practice and the patients we serve depends on it.

## Measures of the Month: Comprehensive Diabetes Care

### Blood Pressure Control

Description: Percentage of patients with diabetes, 18-75 years of age, whose blood pressure was adequately controlled (less than 140/90) during the measurement period based on the most recent blood pressure reading during the measurement period.

### Eye Exam

Description: Percentage of diabetes patients 18-75 years of age who received a dilated eye exam, seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, or imaging validated to match diagnosis from these photos during the measurement period. A negative dilated eye exam (negative for retinopathy) in the prior measurement period also meets criteria for the eye exam indicator.

### HbA1c Control (<8)

Description: Percentage of patients with diabetes, 18-75 years of age, whose most recent HbA1c level was less than 8.0 percent (in control).

### HbA1c Control ( $\leq 9$ )

Description: The percentage of patients with diabetes 18-75 years of age whose most recent HbA1c level during the measurement period was less than or equal to 9.0 percent (in control).

### Medical Attention for Nephropathy

Description: Percentage of diabetes patients 18-75 years of age with at least one test for microalbumin during the measurement period or evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria).

### Why These Measures Matter:

According to the American Diabetes Association, diabetes requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Care is complex and requires that many issues, beyond glycemic control, be addressed. Standards of care are intended to provide the components of diabetes care, treatment goals, and tools to evaluate the quality of care. While individual preferences, comorbidities, and other patient factors may require modification of goals, targets that are desirable for most patients with diabetes are provided. These standards are not intended to preclude more extensive evaluation and management of the patient by other specialists as needed.

## **Best Practice:**

Focus on prevention before treatment, says Cindy Hong Ta Pau, MD, clinician and investigator at the East-West Medical Research Institute and Diabetes and Hormone Center of the Pacific. "We often intervene too late when there is already multi-organ dysfunction," she says. "By the time a patient is diagnosed with diabetes, they already have pancreatic and hepatic dysfunction from a glycemic control standpoint. They may also already have early retinopathy, neuropathy or nephropathy."

It's important to identify patients who are at higher risk for developing diabetes (patients with impaired glucose tolerance, obesity, prior history of gestational diabetes, strong family history, polycystic ovary syndrome, and certain ethnic populations, such as Pacific Islander/Native Hawaiian, Southeast Asian, Mexican, etc.), says Pau. "If you identify that a patient has impaired glucose tolerance, that is the golden opportunity to initiate aggressive lifestyle modifications, and possibly metformin, to prevent progression to full blown diabetes."

For your patients who already have diabetes, treatment needs to be individualized to the patient, says Pau. "There are algorithms, but they are generally not helpful. You have to know what A1c to target and what medications can actually get you there. Therefore, it's important to understand diabetes pharmacology and pharmacodynamics, in addition to prioritizing what the important outcomes and limiting factors are for your patient." For example, weight loss may be a priority, in addition to glycemic control, and renal failure can be a limiting factor in selecting pharmacologic agents, she says.

HHP's September CME program will feature Dr. Pau and focus on the pharmacologic management of diabetes. Stay tuned for more details.

For more information about how to achieve points on the HMSA measures, see p. 56 in [HMSA's Pay for Quality Program Guide](#).

Questions or comments about these measures? Email HHP Marketing Manager Brian Driscoll at [brian.driscoll@hawaiipacifichealth.org](mailto:brian.driscoll@hawaiipacifichealth.org) to share with the HHP team.

## **Annual Meeting: Save the Date!**

The HHP board of managers and administration invite you to attend the HHP Third Annual Membership Meeting on O'ahu on Tuesday, August 30, 2016, 5:30-8 p.m. at the Hawai'i Prince Hotel Waikiki, or on Kaua'i on Tuesday, September 13, 2016, 5:30-8 p.m. at Wilcox Memorial Hospital.



This year's meeting is more about you, the members, and all the work you've done. With a focus on teamwork and collaboration, the meeting will feature roundtable discussions, extended Q&A and more.

*Join us for this opportunity to learn more about:*

- Major accomplishments from the past year
- The road ahead (payment transformation, patients as purchasers, etc.)
- Primary care redesign
- Collaborative care
- Clinical workgroup updates
- Measure development—back to basics

Stay tuned for more information, and register early by calling Conference Services at 808-522-3469 or emailing [conference@hawaiipacifichealth.org](mailto:conference@hawaiipacifichealth.org).

## **HHP Welcomes New Members**

Hawai'i Health Partners would like to welcome the following individuals who were recently appointed by the HHP Board of Managers as new members to the organization:

- Darrell Jun Lee, MD, Gastroenterology, Independent
- Sandra K. Noon, DO, Internal Medicine, Straub Medical Center
- Derek J. Orejel, MD, Internal Medicine, Straub Medical Center
- Harman K. Arora, MD, Emergency Medicine, Wilcox Medical Center
- David F. Della Lana, MD, Family Medicine, Wilcox Medical Center