2024

PROGRAM GUIDE

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

CREATING A HEALTHIER HAWAIʻI

CONTENTS

LETTER TO COLLEAGUES:

The 2024 Quality Performance and Shared Savings Program represents a pivot in our approach to Hawai'i Health Partners as an Accountable Care Organization (ACO). Improving health care quality and efficiency, enhancing patient experience, and stabilizing the ever-increasing total cost of care are still core to our mission.

In 2024, we are focusing on our goal of creating an integrated, coordinated care system with the introduction of the Ecosystem Development Measure. We aim to develop our Ecosystem, our ACO, to understand where the best opportunities to achieve our mission lie. A solid Ecosystem also will create a strong foundation to be more innovative and collaborative in our approach to health care. As an example, HHP has undertaken efforts to evaluate the multiple care coordination programs that exist across the system. By utilizing the facilities and providers in our Ecosystem, we can align their processes to reduce readmissions while also identifying gaps in services to specific populations or regions. Working within the Ecosystem brings us one step closer to ensuring every patient in our network has the best possible outcomes when transitioning from the hospital.

This year also represents a year of simplification. In May 2023, we saw the official end of the COVID-19 Public Health Emergency. However, we did not see a decrease in health care utilization or an improvement in overall health outcomes. We acknowledge the continuous challenges that our clinicians face in caring for our patients. In 2024, we aim to keep clinicians engaged in our mission, our network, and our programs despite these challenges. We hope you find the 2024 program simplified in the number of measures and their relevance to your daily clinical practice.

Finally, we hope the program clearly reinforces our mission of improving health care quality and efficiency, enhancing patient experience, and stabilizing the rising total cost of care by using the skilled clinicians and first-rate health care facilities that make up our Ecosystem.

As always, we remain committed to listening, supporting, and advocating for you in our provider services, partnerships, and programs. Thank you for leading the transformation of health care in Hawai'i.

Sincerely,
Jennifer Lo, MD
Medical Director

Hawai'i Health Partners Overview

As the state's first physician-led Accountable Care Organization (ACO), Hawai'i Health Partners (HHP) manages the integration of a high-performing network of providers, facilities, and hospitals aligned to provide patient-centered, high-quality care. We are a physician-led ACO with a goal to improve health care in Hawai'i by focusing on value-based care, increasing efficiency, and developing a network that provides highly coordinated care with optimal patient health outcomes.

To engage individual providers under these goals, Hawai'i Health Partners has a performance program – the Quality Performance and Shared Savings Program – with potential for incentive payments.

Quality Performance and Shared Savings Program

The Quality Performance and Shared Savings Program is designed to engage and recognize providers who contribute to achieving quality performance goals in the inpatient setting and improving population health, benefiting the care of HHP's attributed members.

Eligibility Criteria

A provider is eligible to receive incentives under this program if all of the following criteria have been met:

1. The provider is a credentialed, participating provider of HHP for at least 90 days of the measurement year.
2. The provider meets the quality thresholds for those applicable measures, based on the provider's specialty or clinical practice area and the minimum patient threshold for measures with defined thresholds.

Performance Target

Performance Target for each measure is based off individual performance, primary facility, or by Clinical Practice Area (CPA). CPA is determined at the time of HHP credentialing as the specialty in which you are practicing.

- Example: Specialty = Internal Medicine and CPA = Hospitalist - IM

Individual vs. Group Provider Participation

Individual performance and incentives will be calculated for all eligible HHP providers, regardless of whether the provider joins as an individual or as a member of a group. For providers participating as members of a group, allocation of incentives and related funds will be made to the group. It is the group's discretion as to how those funds are distributed to its providers.

Measurement Period

The quality program starts on January 1, 2024, and ends December 31, 2024. Progress can be monitored through the use of the HHP Primary Care and Specialty Dashboards. However, final eligibility for incentive payments and final performance scores are determined after the end of the calendar year. Payment will be made following determination of fund availability. For more information, email Info@HawaiiHealthPartners.org.

PARTICIPATION IN ECOSYSTEM, PERFORMANCE AND BONUS MEASURES BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	ECO-SYSTEM	PERFORMANCE MEASURES									BONUS MEASURES	
	Ecosystem Development	Annual Assessment of Chronic Conditions	Avoidable ED Utilization	HHP Network Engagement	Hospital-Acquired Harm	Increasing Ambulatory Surgery Center Use	Mammogram Imaging Callback Rate	Sepsis and Septic Shock Management Bundle	Turnaround Time	Vermont Oxford Network for VLBW and Expanded Database Measures	HHP Network Engagement Presenter	Participation in HHP Clinical Workgroups and Committee Leadership
PRIMARY CARE (carrying a primary care panel of patients)												
Family Medicine (PCP)	✔		✔	✔	✔						✔	✔
General Practice (PCP)	✔		✔	✔	✔						✔	✔
Internal Medicine (PCP)	✔		✔	✔	✔						✔	✔
Pediatrics (PCP)	✔		✔	✔	✔						✔	✔
Physician Assistant or Advanced Practice RN	✔		✔	✔	✔						✔	✔
SPECIALIST												
Adolescent Medicine (non-PCP)	✔	✔	✔	✔	✔						✔	✔
Allergy & Immunology	✔	✔	✔	✔	✔						✔	✔
Anesthesiology	✔	✔		✔	✔						✔	✔
Cardiac Electrophysiology	✔	✔	✔	✔	✔						✔	✔
Cardiology	✔	✔	✔	✔	✔						✔	✔
Cardiothoracic Surgery	✔	✔	✔	✔	✔						✔	✔
Child & Adolescent Psychiatry	✔	✔	✔	✔	✔						✔	✔
Clinical Psychology	✔	✔	✔	✔	✔						✔	✔
Critical Care Medicine	✔	✔		✔	✔			✔			✔	✔
Dermatology	✔	✔	✔	✔	✔						✔	✔
Dermatopathology	✔	✔		✔	✔				✔		✔	✔
Developmental-Behavioral Peds	✔	✔	✔	✔	✔						✔	✔
Diagnostic Radiology	✔	✔		✔	✔		✔		✔		✔	✔
Emergency Medicine	✔	✔	✔	✔	✔			✔			✔	✔
Endocrinology	✔	✔	✔	✔	✔						✔	✔
Family Medicine (non-PCP)	✔	✔	✔	✔	✔						✔	✔

PARTICIPATION IN ECOSYSTEM, PERFORMANCE AND BONUS MEASURES BY CLINICAL PRACTICE AREA

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Gastroenterology	✔	✔	✔	✔	✔	✔					✔	✔
General Practice (non-PCP)	✔	✔	✔	✔	✔						✔	✔
General Surgery	✔	✔	✔	✔	✔	✔					✔	✔
Geriatric Medicine	✔	✔	✔	✔	✔						✔	✔
Geriatric Psychiatry	✔	✔	✔	✔	✔						✔	✔
Gynecologic Oncology	✔	✔	✔	✔	✔						✔	✔
Gynecology	✔	✔	✔	✔	✔	✔					✔	✔
Hematology/Oncology	✔	✔	✔	✔	✔						✔	✔
Hospice & Palliative Medicine	✔	✔	✔	✔	✔						✔	✔
Hospitalist – Family Medicine	✔	✔	✔	✔	✔			✔			✔	✔
Hospitalist – Internal Medicine	✔	✔	✔	✔	✔			✔			✔	✔
Hospitalist – Pediatrics	✔	✔	✔	✔	✔						✔	✔
Infectious Disease	✔	✔	✔	✔	✔						✔	✔
Internal Medicine (non-PCP)	✔	✔	✔	✔	✔						✔	✔
Interventional Cardiology	✔	✔	✔	✔	✔						✔	✔
Interventional Radiology	✔	✔	✔	✔	✔				✔		✔	✔
Long-Term Care	✔	✔	✔	✔	✔						✔	✔
Maternal & Fetal Medicine	✔	✔	✔	✔	✔						✔	✔
Medical Genetics	✔	✔		✔	✔						✔	✔
Medical Oncology	✔	✔	✔	✔	✔						✔	✔
Neonatology	✔	✔		✔	✔					✔	✔	✔
Nephrology	✔	✔	✔	✔	✔						✔	✔
Neurology	✔	✔	✔	✔	✔						✔	✔

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Neuroradiology	✔	✔		✔	✔				✔		✔	✔
Neurosurgery	✔	✔	✔	✔	✔						✔	✔
Nuclear Medicine	✔	✔		✔	✔				✔		✔	✔
Obstetrics & Gynecology	✔	✔	✔	✔	✔	✔					✔	✔
Occupational Medicine	✔	✔	✔	✔	✔						✔	✔
Ophthalmology	✔	✔	✔	✔	✔	✔					✔	✔
Orthopedic Surgery	✔	✔	✔	✔	✔	✔					✔	✔
Otolaryngology	✔	✔	✔	✔	✔	✔					✔	✔
Pain Management	✔	✔	✔	✔	✔						✔	✔
Pathology	✔	✔		✔	✔				✔		✔	✔
Pediatric Anesthesiology	✔	✔		✔	✔						✔	✔
Pediatric Cardiology	✔	✔	✔	✔	✔						✔	✔
Pediatric Critical Care	✔	✔		✔	✔						✔	✔
Pediatric Diagnostic Radiology	✔	✔		✔	✔				✔		✔	✔
Pediatric Emergency Medicine	✔	✔	✔	✔	✔						✔	✔
Pediatric Endocrinology	✔	✔	✔	✔	✔						✔	✔
Pediatric Gastroenterology	✔	✔	✔	✔	✔						✔	✔
Pediatric Hematology/ Oncology	✔	✔	✔	✔	✔						✔	✔
Pediatric Infectious Disease	✔	✔	✔	✔	✔						✔	✔
Pediatric Nephrology	✔	✔	✔	✔	✔						✔	✔
Pediatric Neurology	✔	✔	✔	✔	✔						✔	✔
Pediatric – NICU	✔	✔		✔	✔					✔	✔	✔
Pediatric Ophthalmology	✔	✔	✔	✔	✔						✔	✔
Pediatric Orthopedic Surgery	✔	✔	✔	✔	✔						✔	✔

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Pediatric Physical Medicine & Rehab	✔	✔	✔	✔	✔						✔	✔
Pediatric Pulmonology	✔	✔	✔	✔	✔						✔	✔
Pediatric Rheumatology	✔	✔	✔	✔	✔						✔	✔
Pediatric Sports Medicine	✔	✔	✔	✔	✔						✔	✔
Pediatric Surgery	✔	✔	✔	✔	✔						✔	✔
Pediatric Urology	✔	✔	✔	✔	✔	✔					✔	✔
Pediatrics (non-PCP)	✔	✔	✔	✔	✔						✔	✔
Physical Medicine & Rehab	✔	✔	✔	✔	✔						✔	✔
Plastic Surgery	✔	✔	✔	✔	✔	✔					✔	✔
Podiatry	✔	✔	✔	✔	✔	✔					✔	✔
Psychiatry	✔	✔	✔	✔	✔						✔	✔
Pulmonology	✔	✔	✔	✔	✔						✔	✔
Radiation Oncology	✔	✔	✔	✔	✔						✔	✔
Repro Endocrin/Infertility	✔	✔	✔	✔	✔						✔	✔
Rheumatology	✔	✔	✔	✔	✔						✔	✔
Sleep Medicine	✔	✔	✔	✔	✔						✔	✔
Sports Medicine	✔	✔	✔	✔	✔						✔	✔
Surgical Oncology	✔	✔	✔	✔	✔						✔	✔
Urgent Care/Walk-In	✔	✔	✔	✔	✔						✔	✔
Urogynecology & Pelvic Reconstruction	✔	✔	✔	✔	✔						✔	✔
Urology	✔	✔	✔	✔	✔	✔					✔	✔
Vascular Surgery	✔	✔	✔	✔	✔						✔	✔
Weight Management	✔	✔	✔	✔	✔						✔	✔
Wound Care	✔	✔	✔	✔	✔						✔	✔

ECOSYSTEM DEVELOPMENT MEASURE

ECOSYSTEM DEVELOPMENT MEASURE

Measure Objective

Due to the importance of this measure, the threshold set by CPA must be achieved and maintained throughout the year in order to earn points for all subsequent measures. An accountable care organization (ACO) is defined as a group of health care providers that accept collective accountability for the cost and quality of care delivered to the patients they serve. ACO clinicians work together, coordinating to provide quality, integrated care. Patients benefit when their physicians are committed to team-based care and accept their role in reducing health care costs. The Ecosystem is foundational to the success of HHP as an ACO. This measure strives to create a strong Ecosystem where our patients receive care managed by our clinicians. Within our HHP Ecosystem, we have the opportunity to:

- Improve communication and coordination of care.
- Increase understanding of network strengths and opportunities for improvement.
- Support maintenance and monitoring of quality.
- Allow ability to innovate within our network.
- Support value-based efforts and initiatives.

Description

Percentage of care for HHP patients delivered by HHP providers in network clinics and facilities.

Numerator

Primary Care: All In-Network HMSA Commercial Claims

Specialists: All In-Network HMSA Commercial Claims

Denominator

Primary Care: All HMSA Commercial claims for the PCPs' attributed patients with a service date in 2024, minus exclusions below.

Specialists: All HMSA Commercial claims billed by HHP Specialist, including facility claims and other specialists to whom HHP specialist refers, minus exclusions on next page.

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Exclusion

Out-of-network claims in the areas of care delivery listed below will be excluded from measurement calculation. Exclusions are based on the following criteria:

1. Area of care delivery has no in-network options.
2. Care delivery options exist in-network, but opportunities for enhancing quality and/or cost are limited.
    - Addiction Medicine
    - Ambulance
    - Anesthesiology
    - Audiologist
    - Certified Registered Nurse Anesthetist
    - Clinical Laboratory
    - Clinical Psychologist
    - Dentist
    - Durable Medical Equipment
    - Family Planning Clinic
    - Genetics
    - Home Infusion
    - Licensed Clinical Social Worker
    - Marriage, Family, Child Counselor
    - Occupational Therapist
    - Optician
    - Orthotics and Prosthetics
    - Out-of-State Claims
    - Pathology
    - Pharmacy
    - Physiotherapist
    - Psychiatric Hospital
    - Psychiatry
    - Psychologist
    - Registered Dietitian/Nutrition Professional
    - Renal Dialysis Clinic
    - Skilled Nursing Facility
    - Speech Therapist
    - Substance Abuse Facility

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ECOSYSTEM DEVELOPMENT MEASURE

Measurement Period

January 1, 2024 - December 31, 2024

Performance Target

Performance is measured on an individual level. Targets are set on baseline data from July 2022 to June 2023 for each Clinical Practice Area and are reflected on the HHP dashboard.

Please see Appendix for your Clinical Practice Area target.

If you have any questions about your performance target, contact Info@HawaiiHealthPartners.org to arrange a meeting.

Practice Location	Target
PCP – O'ahu	CPA Mean – 2 Standard Deviations
PCP – Neighbor Island	CPA Mean – 3 Standard Deviations
Specialist – O'ahu	Target is lesser of 65% or CPA Mean – 2 Standard Deviations
Specialist – Neighbor Island	Target is lesser of 65% or CPA Mean – 3 Standard Deviations

Eligible Members

All HHP Credentialed Members

How to Meet the Measure

How to Monitor Performance:
Clinicians can monitor performance on the HHP dashboard. If you need help accessing your dashboard, please contact HHP:

- **Primary Care Physicians:** Contact your Population Health Liaison or email PCP.Dashboard@HawaiiHealthPartners.org
- **Specialists:** Email Specialist.Dashboard@HawaiiHealthPartners.org

Providers whose CPA does not have qualifying baseline data:
They can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.

Providers with less than 10 claims or are new to HHP in 2024:
They can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.

If you have questions regarding opportunities to meet this measure for your clinical practice area, please email: Info@HawaiiHealthPartners.org.

PERFORMANCE PROGRAM MEASURES

ANNUAL ASSESSMENT OF CHRONIC CONDITIONS

Measure Objective	HHP's focus is to provide value-based programs that engage and recognize physicians who deliver high-quality care and improve patient health outcomes. To be successful, clinicians need to describe the complexity of illnesses that impact our patient population through the use of appropriate ICD-10 codes. These complexities serve as the basis for risk adjustment models that determine a patient's expected health outcome and the level of reimbursement for our care. By clearly demonstrating the burden of illness that our patients face, we can define a more realistic goal of success both in health care outcomes and financial stewardship (affordability, cost, spend, utilization) while identifying the resources to achieve these outcomes.
Description	Annual Assessment of Chronic Conditions Measure aims to improve the understanding of risk-adjustment and its importance in describing disease complexity in value-based care. Educational sessions will provide information on HCCs and ICD-10 codes related to these conditions, how these diseases are identified in daily practice, and how providers can acknowledge a patient's chronic condition annually to support the efforts of value-based care.
Exclusion	N/A
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	Both educational sessions completed by deadline
Minimum Case Threshold	N/A
Eligible Members	All HHP Specialists
How to Meet the Measure	To obtain full credit for the measure, providers who are credentialed in the HHP network prior to May 31, 2024, must complete: • First educational session by June 30, 2024, AND • Second educational session by December 31, 2024 Physicians/Providers who are credentialed in the HHP network after May 31, 2024, can attain full credit for this measure if both educational sessions are completed prior to December 31, 2024.

AVOIDABLE ED UTILIZATION

Measure Objective	ED visits can be a tremendous burden to the patient and health care system, especially for those conditions that can be treated outside of the ED.[1] Avoidable ED visits can hinder access to emergency care and cost over $4 billion annually. Outpatient-based clinicians play an important role in empowering patients to seek care in the most effective care setting. In addition, hospital-based services can impact repeat ED utilization or readmissions through the care they deliver. This measure aims to direct patients to seek care in the most appropriate setting to meet their needs.
Description	Percentage of ED visits by HMSA Commercial attributed patients that are "avoidable" according to adapted NYU criteria
Numerator	Patient ED visits from the denominator that are "avoidable" according to adapted NYU criteria
Denominator	HMSA Commercial attributed patients that present to an ED
Exclusions	N/A
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	**Primary Care:** Individual performance scored at or below 25% in HHP Dashboard **Specialists: Overall HHP aggregate score** at or below 25%
Eligible Members	**Primary Care:** Family Medicine, General Practice, Internal Medicine, Pediatrics, and APRNs carrying a primary care panel of attributed lives **Specialists:** All specialties excluding: Anesthesiology, Critical Care Medicine, Dermatopathology, Diagnostic Radiology, Medical Genetics, Neonatology, Neuroradiology, Nuclear Medicine, Pathology, Pediatric Critical Care, Pediatric Diagnostic Radiology, and Pediatrics – NICU
How to *Monitor* the Measure	**Primary Care:** Monitor your panel's avoidable ED visits on the HHP Primary Care Dashboard in Epic (see next page). **Specialists:** Monitor the overall HHP avoidable ED performance on your scorecard on the HHP Specialist Dashboard in Epic.

[1]*From https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html. Retrieved on 11/15/2023*

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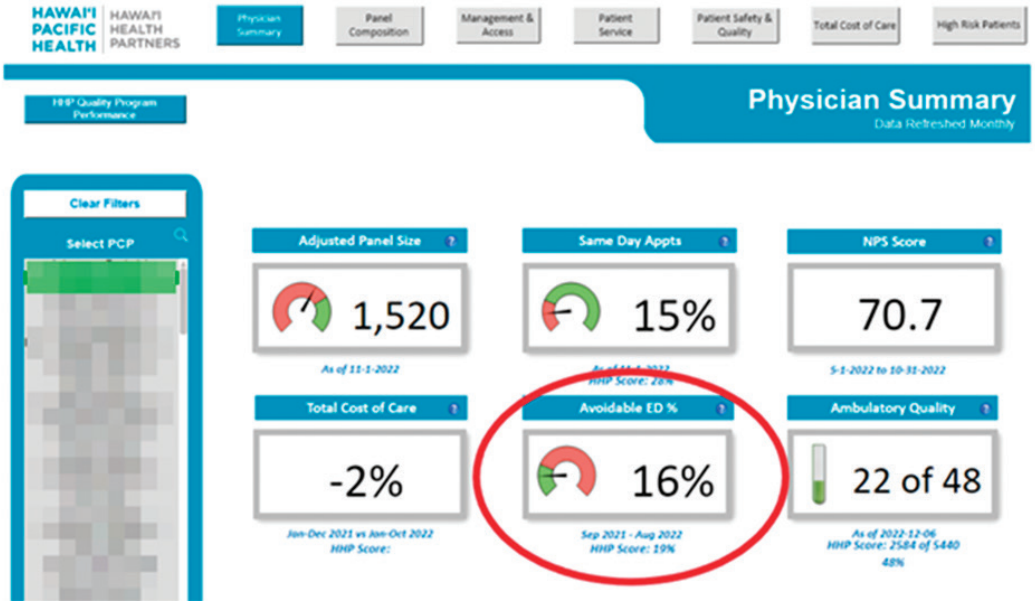
AVOIDABLE ED UTILIZATION

Hawai'i Health Partners PCP Dashboard



Each ED visit is considered "avoidable" as determined by the NYU Avoidable ED algorithm. This is determined for attributed lives for each PCP (attribution is based on the HMSA eligibility file). Both the primary and secondary diagnoses will be evaluated to determine if the visit was avoidable. A visit is considered avoidable if the likelihood of that visit falls into the first three of the following four categories:

1. **Non-Emergent (ED level 1):**
   The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours.

2. **Emergent/Primary Care Treatable (ED level 2):**
   Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests).

3. **Emergent – ED Care Needed – Preventable/Avoidable (ED level 3):**
   Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.)

4. **Emergent – ED Care Needed – Not Preventable/Avoidable (ED level 4):**
   Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

Specifications and background for the NYU Avoidable ED Visit algorithm are available at: https://wagner.nyu.edu/faculty/billings/nyued-background

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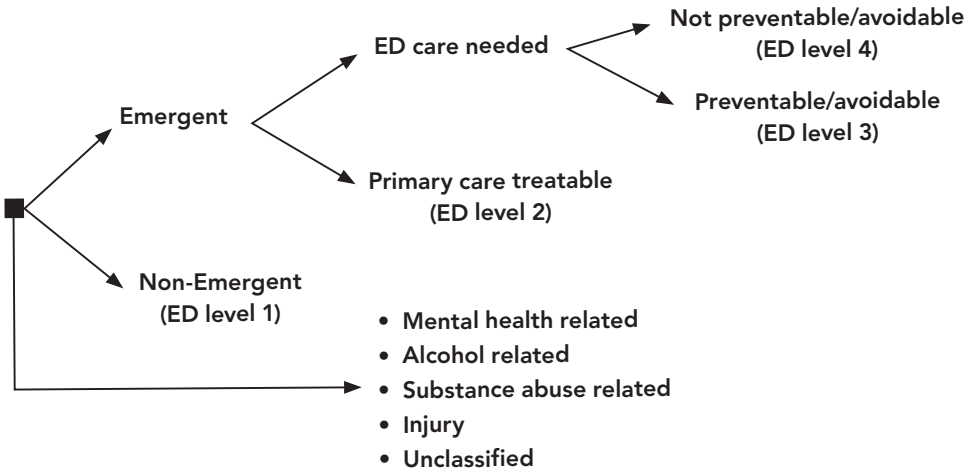
AVOIDABLE ED UTILIZATION



HHP NETWORK ENGAGEMENT

Measure Objective	Providers are the cornerstone to making health care transformation work. Your involvement and engagement in HHP activities are critical to our success. This measure encourages and provides opportunities for information sharing and engagement with HHP members.
Description	Attendance and participation at the HHP Webinars
Exclusions	N/A
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	6 webinars attended (attended live OR viewed recording and correctly answered questions within 4 weeks of live webinar)
Eligible Members	All eligible HHP credentialed members
How to Meet the Measure	**Attend live webinar:** Providers must register via the pre-survey form and attend at least 6 live webinars during the measurement year. **Recording and test questions:** Credit may be given if providers view the recording and correctly answer post-video questions within 4 weeks of the live webinar.

HOSPITAL-ACQUIRED HARM

Measure Objective	Office Inspector General wrote a brief reporting that 25% of Medicare patients experienced harm during hospital stays occurring in a 1-month period, resulting in over $300 million in additional costs. Approximately 43% of events were preventable. This measure intends to engage hospital-based physicians in efforts to eliminate six types of hospital-acquired harm: Central Line-Associated Blood Stream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Clostridium difficile infections, Methicillin-Resistant Staphylococcus Aureus (MRSA) infections, hospital-associated injury, and hospital-acquired stage 3 or 4 pressure ulcers, thereby improving safety and reducing health care costs in our inpatient facilities.
Description	This outcomes-based measure rewards strategies to reduce hospital-acquired harm depending on the condition, which include but are not limited to: reduction of central line or urinary catheter days, recognition and early testing of patients at risk for C. difficile identified at time of admission, respectful interaction with clinical staff regarding appropriate identification, and management of patients at risk for harm.
Numerator	Total number of harm incidents
Denominator	Number of patient days
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	Full credit: ≤2 events / 10,000 patient days in **aggregate by facility** Partial credit: ≤6 events / 10,000 patient days in **aggregate by facility**
Minimum Case Threshold	5 hospital encounters (inpatient or ED)
Eligible Members	All HHP members who meet the minimum case threshold of 5 hospital encounters during the measurement period with hospital activity

CARE COORDINATION

INCREASING AMBULATORY SURGERY CENTER USE

Measure Objective	Shifting procedures from hospital settings to ambulatory surgical centers could save millions of dollars annually while increasing patient satisfaction and improving access. This measure intends to promote movement of appropriate cases into an ambulatory surgery center.
Description	Increase the rate of appropriate surgical cases completed in an ambulatory surgery center
Numerator	Total number of cases performed in an ambulatory surgery center
Denominator	Total number of cases performed in an ambulatory surgery center and/or hospital-based facility
Exclusion	Surgical cases performed on patients determined to be ASA Class III or higher as defined by the American Society of Anesthesiology Physical Status Classification System
Measurement period	January 1, 2024 - December 31, 2024
Performance Target	Case Performance Target set by ASC case rate for period July 1, 2022-June 30, 2023, by specialty group. ASC Case Rate = Total number of cases performed at ASC/Total number of cases performed in ASC OR hospital-based facility • Gastroenterology: 42% • General Surgery: 8% • Gynecology/Obstetrics & Gynecology: 6% • Ophthalmology: 87% • Orthopedic Surgery: 59% • Otolaryngology: 46% • Pediatric Urology: 12% • Plastic Surgery: 12% • Podiatry: 47% • Urology: 27%
Minimum Case Threshold	50 total eligible cases performed by given specialty
Eligible Members	• Gastroenterology • General Surgery • Gynecology/Obstetrics & Gynecology • Ophthalmology • Orthopedic Surgery • Otolaryngology • Pediatric Urology • Plastic Surgery • Podiatry • Urology
How to Meet the Measure	Complete the target case rate as a specialty group in an ambulatory surgery center.

MAMMOGRAM IMAGING CALLBACK RATES

Measure Objective	High-quality screening mammography has been shown to substantially reduce mortality from breast cancer. Mammogram imaging callback rate is a performance measure because it directly relates to the rate of false-positive examinations.[2] This measure intends to reduce variation in mammogram imaging callback rates, thereby balancing the need to detect breast cancer while avoiding stressful and costly additional images.
Description	A callback rate, or the frequency that patients are asked to come back for additional images from screening, between 5% and 14% aligns with national recommendations from the Agency for Healthcare Research and Quality (AHRQ) and the American College of Radiology (ACR), as well as systematic reviews of the existing scientific literature. 1. *Nelson HD, Cantor A, Humphrey L, et al. Screening for breast cancer: a systematic review to update the 2009 U.S. Preventive Services Task Force Recommendation. Rockville, MD: Agency for Healthcare Research and Quality, 2016: January Report No.: 14-05201-EF-1* 2. *Sickles EA, D'Orsi CJ, Bassett LW, et al. ACR BI-RADS mammography, 5th ed. In: D'Orsi CJ, Sickles EA, Mendelson EB, et al. ACR BI-RADS atlas: Breast Imaging Reporting and Data System. Reston, VA: American College of Radiology, 2013* 3. *Grabler P, Sighoko D, Wang L, Allgood K, Ansell D. Recall and cancer detection rates for screening mammography: Finding the sweet spot. American Journal of Roentgenology. 2017;208(1):208-213. doi:10.2214/ajr.15.15987*
Numerator	Number of mammograms identified as needing additional imaging evaluation
Denominator	Total number of mammograms performed
Exclusion	N/A
Measurement period	January 1, 2024 - December 31, 2024
Performance Target	**Aggregate score by facility** between 5% and 14%* **If HHP determines that a facility's mammogram imaging callback rate exceeded 14% during the measurement period because additional testing was medically necessary for the facility's patients, then HHP may adjust that facility's Performance Target accordingly.*
Minimum Case Threshold	480 mammograms interpreted during the measurement period
Eligible Members	Specialists: Diagnostic Radiology

[2]*Lee CS, Parise C, Burleson J, Seidenwurm D. Assessing the Recall Rate for Screening Mammography: Comparing the Medicare Hospital Compare Dataset With the National Mammography Database. AJR Am J Roentgenol. 2018 Jul;211(1):127-132. doi: 10.2214/AJR.17.19229. Epub 2018 May 24. PMID: 29792737.*

SEPSIS AND SEPTIC SHOCK: MANAGEMENT BUNDLE (COMPOSITE MEASURE)

Measure Objective

Patients who develop sepsis are at high risk for complications and death and have higher health care costs. Early recognition and treatment are associated with decreased mortality and improved patient outcomes. This measure intends to encourage use of best practices to support comprehensive care of sepsis and septic shock.

Description

Cumulative monthly sepsis and septic shock core measure result (%)

This measure will focus on patients aged 18 years and older who present with symptoms of sepsis or septic shock. These patients will be eligible for the 3-hour (sepsis) and/or 6-hour (septic shock) early management bundle (ref: CMS measure: SEP-1).

Numerator

Patients from the denominator who received all the following care elements (see A, B, and C below) within 3 hours of time of presentation.

If septic shock is present (defined by hypotension or lactate >=4 mmol/L), patients from the denominator who also received additional care elements (see D, E, F, and G below) within 6 hours of time of presentation.

A. Measure lactate level.
B. Obtain blood cultures prior to antibiotics.
C. Administer broad spectrum antibiotics.
D. Administer 30 ml/kg crystalloid for hypotension or lactate >=4 mmol/L.
E. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >= 65 mm Hg).
F. In the event of persistent hypotension after initial fluid administration (MAP <65 mm Hg) or if initial lactate was >=4 mmol/L, re-assess volume status and tissue perfusion and document findings.

   To meet the requirements, a focused exam by a licensed independent practitioner (LIP) or any 2 other items are required:

   - Measure CVP
   - Measure ScvO2
   - Bedside cardiovascular ultrasound
   - Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge
   - Focused exam including vital signs, cardiopulmonary, capillary refill, pulse and skin findings

G. Remeasure lactate if initial lactate is elevated.

Denominator

All patients presenting with sepsis or septic shock and discharged with a diagnosis of sepsis or septic shock (the cohort is defined by discharge coding)

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SEPSIS AND SEPTIC SHOCK: MANAGEMENT BUNDLE (COMPOSITE MEASURE)

Exclusion	A. Patients with advanced directives for comfort care B. Clinical conditions that preclude total measure completion (e.g., mortality within the first 6 hours of presentation) C. Patients for whom a central line is clinically contraindicated (e.g., coagulopathy that cannot be corrected, inadequate internal jugular or subclavian central venous access due to repeated cannulations) D. Patients for whom a central line was attempted but could not be successfully inserted E. Patient or surrogate decision maker declined or is unwilling to consent to such therapies or central line placement F. Patients transferred to an acute care facility from another acute care facility
Measurement period	January 1, 2024 - December 31, 2024
Performance Target	To be scored in **aggregate by facility** ≥70%
Eligible Members	Provider specialties listed below who have cared for a sepsis patient in the measurement year: • Critical Care Medicine • Emergency Medicine • Hospitalist – Family Medicine • Hospitalist – Internal Medicine

TURNAROUND TIME

Measure Objective	Timely reports are one of the most important tools physicians use to adequately manage the quality and safety of patient care. Turnaround Time (TAT) acts as a quality indicator to evaluate the effectiveness and efficiency of the testing process and the satisfaction of clinicians and patients.
Description	**Pathology:** Average turnaround time for pathology report **Diagnostic Imaging:** Average turnaround time for radiology report
Numerator	Time from order to signing of report cumulative for all orders (in hours)
Denominator	Total number of orders
Exclusions	**Pathology:** Frozen section pathology reports **Diagnostic imaging:** Critical results, including code stroke
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	**Pathology:** Breast, Cervical, Colorectal, Skin – less than 72 hours **Imaging:** Average turnaround time – less than 24 hours
Minimum Case Threshold	**Pathology:** 10 cases **Imaging:** 36 cases
Eligible Members	Dermatopathology, Diagnostic Radiology, Interventional Radiology, Neuroradiology, Nuclear Medicine, Pathology, Pediatric Diagnostic Radiology
How to Meet the Measure	Complete read and report documentation within specific time frame.

VERMONT OXFORD NETWORK (VON) FOR VLBW AND EXPANDED DATABASE MEASURES

Measure Objective	VON is a voluntary, worldwide interdisciplinary community dedicated "to giving infants the best possible start so that every newborn and family achieves their fullest potential".[3] This measure uses the VON VLBW and Expanded Database to optimize clinical management of sick newborns.
Description	The amount of points earned by an eligible provider under the VON measures for very low birth weight (VLBW) and expanded database patients • VLBW – Nosocomial infection • VLBW – Any human milk by discharge to home • VLBW – Death or morbidity • Expanded – Nosocomial infection • Expanded – Any human milk by discharge to home • Expanded – Mortality excluding early deaths
Numerator	Patients who meet each individual VON metric criteria
Denominator	All patients admitted to the NICU at Kapi'olani Medical Center for Women & Children (KMCWC) Expanded definition: All NICU admissions VLBW definition: All very low birth weight NICU admissions (a subset of the expanded dataset)
Exclusion	• Admitted from home after being hospitalized • Admitted ≥ 28 days of life
Measurement period	January 1, 2023 - December 31, 2023
Performance Target	Top quartile for each of the 6 measures
Eligible Members	Neonatologists and Pediatric – NICU physicians who are members of the Hawai'i Pacific Health Medical Group Division of Neonatology

[3]*From https://public.vtoxford.org/who-we-are-overview/. Retrieved 11/15/2023*

BONUS MEASURES

HHP NETWORK ENGAGEMENT – PRESENTER

Measure Objective	Providers are the cornerstone to making health care transformation work. Your involvement and engagement in HHP activities are critical to our success. This measure encourages and provides opportunities for information sharing and engagement with HHP members.
Description	Present at a HHP 2024 webinar
Exclusions	N/A
Measurement Period	January 1, 2024 - December 31, 2024
Eligible Members	All eligible HHP credentialed members
How to Meet the Measure	**Present at a webinar:** Presenters at HHP webinars are eligible to earn points if they attest to at least 2 hours of work in preparation for the presentation.

PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

Measure Objective	Value-based care prioritizes care delivery concepts, including population health, quality, care coordination, and cost of care, that are often difficult to incorporate into our traditional health care workflows. The intent of this measure is to increase multispecialty participation in HHP-chartered hospital or ambulatory clinical workgroups, which focus on developing and implementing standards of care for these concepts in our day-to-day work. Chairing an HHP committee offers a unique service opportunity to improve the leadership and direction of the ACO in areas around quality, affordability, and maintaining a strong provider network.
Description	Participation in HHP-chartered clinical workgroups that promote HHP value-based care objectives or serving as a chair for an HHP committee.
Inclusion	All eligible HHP-credentialed members
Exclusion	N/A
Measurement Period	January 1, 2024 - December 31, 2024
Performance Target	Active participation in workgroups as reflected by attendance of at least 75% and demonstration of meaningful participation of workgroup member
Eligible Members	All eligible HHP members
How to Meet the Measure	Workgroup members are required to participate in at least 75% of meetings and/or contribute through the demonstration of actionable and verifiable work. Actual, verifiable work is defined as completing a workgroup task appropriate to the skills, education and/or training of a physician/provider member that is documented in the minutes. Examples include researching and sharing evidence on appropriate use to the workgroup, presenting a case study to inform colleagues about a more efficient care delivery process/treatment method, or leading a discussion with colleagues about reducing practice variation within the group. Attendance and meaningful participation must be performed by physician/provider member and not by a staff proxy. **Attendance and meaningful participation must be captured in meeting minutes, verified by workgroup chair, and then summarized in quarterly reporting to the Quality and Clinical Integration (QCI) Committee.**

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PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

Workgroup Chair Job Description

Each workgroup chair must be willing to assume the responsibility of ensuring a smoothly run and effective team.

The chair is expected to:

1. Ensure continued alignment of workgroup deliverables with shared savings and hospital quality performance interests.
2. Report workgroup status updates to the QCI Committee on a quarterly basis or more frequently as needed.
3. Develop specific expected outcomes and methods to track and measure progress.
4. Ensure adequate documentation of all workgroup-related activities.
5. Ensure sustained engagement and participation of workgroup members.
6. Ensure workgroup produces stated deliverables in established timeline.
7. Include a plan for communicating any clinical process change or implementation.
8. Identify dependencies external to the workgroup and interact with the necessary departments or individuals to address the issue (e.g., working with Epic project management to modify an Epic workflow).
9. Maintain a workgroup environment that welcomes all points of view, with a willingness to thoroughly discuss contentious or complex issues.
10. Encourage support for decisions made by majority rule.
11. Produce final document at the close of the workgroup summarizing work performed, results achieved, and lessons learned.

Committee Chair Job Description

Eligible HHP committees include:

- Credentialing Committee
- Finance Committee
- Nominating Committee
- Quality and Clinical Integration Committee

The chair is expected to:

1. Create an agenda appropriate to the committee.
2. Review and critique the material to be presented prior to the committee meeting.
3. Attend and facilitate the committee meeting.
4. Report to the HHP Board of Managers about committee activities.
5. Maintain Roberts Rules of Order in the conduct of the meeting.
6. Review and revise minutes describing committee activities.
7. Meet as needed with HHP leadership to strategically plan future direction of the committee.

APPENDIX

ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	O'AHU THRESHOLD	NEIGHBOR ISLAND THRESHOLD
PRIMARY CARE		
Family Medicine (PCP)	36%	23%
General Medicine (PCP)	55%	49%
Internal Medicine (PCP)	55%	49%
Pediatrics (PCP)	53%	44%
SPECIALIST		
Adolescent Medicine	65%	65%
Allergy & Immunology	65%	65%
Anesthesiology	65%	59%
Cardiac Electrophysiology	65%	65%
Cardiology	65%	65%
Cardiothoracic Surgery	65%	65%
Clinical Psychology	65%	65%
Critical Care Medicine	65%	65%
Dermatology	33%	5%
Dermatopathology	65%	65%
Diagnostic Radiology	65%	65%
Emergency Medicine	53%	34%
Endocrinology	65%	65%
Gastroenterology	65%	65%
General Practice (Non-PCP)	65%	65%
General Surgery	65%	65%
Geriatric Medicine	63%	52%
Gynecologic Oncology	65%	65%
Gynecology	65%	65%
Hematology/Oncology	65%	65%
Hospice & Palliative Medicine	65%	65%
Hospitalist – Family Medicine/Internal Medicine	52%	34%
Hospitalist – Pediatrics	65%	58%
Infectious Disease	65%	65%
Interventional Cardiology	65%	65%
Maternal & Fetal Medicine	65%	65%
Neonatology/Pediatric – NICU	65%	65%
Nephrology	39%	14%
Neurology	65%	65%
Neuroradiology	65%	65%
Neurosurgery	65%	65%
Obstetrics & Gynecology	57%	38%
Occupational Medicine	65%	65%

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ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	O'AHU THRESHOLD	NEIGHBOR ISLAND THRESHOLD
Ophthalmology	54%	35%
Orthopedic Surgery	61%	45%
Otolaryngology	65%	65%
Pain Management	65%	65%
Pediatric Anesthesiology	65%	65%
Pediatric Cardiology	65%	65%
Pediatric Critical Care	65%	65%
Pediatric Diagnostic Radiology	65%	65%
Pediatric Emergency Medicine	65%	65%
Pediatric Endocrinology	65%	65%
Pediatric Gastroenterology	65%	65%
Pediatric Hematology/Oncology	65%	65%
Pediatric Infectious Diseases	65%	65%
Pediatric Nephrology	65%	65%
Pediatric Neurology	62%	48%
Pediatric Ophthalmology	65%	65%
Pediatric Orthopedic Surgery	65%	65%
Pediatric Physical Medicine & Rehab	65%	65%
Pediatric Pulmonology	65%	65%
Pediatric Rheumatology	65%	65%
Pediatric Sports Medicine	65%	65%
Pediatric Surgery	65%	65%
Pediatric Urology	65%	65%
Pediatrics (Non-PCP)	65%	56%
Physical Medicine & Rehab	65%	65%
Plastic Surgery	65%	65%
Podiatry	65%	65%
Pulmonology	65%	64%
Radiation Oncology	65%	65%
Repro Endocrine/Infertility	65%	65%
Rheumatology	65%	65%
Sleep Medicine	65%	65%
Sports Medicine	65%	65%
Surgical Oncology	65%	65%
Urgent Care/Walk-In	65%	65%
Urogynecology & Pelvic Reconstruction	65%	65%
Urology	65%	65%
Vascular Surgery	65%	65%
Weight Management	65%	65%
Wound Care	47%	38%

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ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

Providers whose CPA does not have qualifying baseline data:	**Providers can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.**
Child & Adolescent Psychiatry	
Developmental-Behavioral Peds	
Geriatric Psychiatry	
Interventional Radiology	
Long-Term Care	
Medical Genetics	
Medical Oncology	
Nuclear Medicine	
Pathology	
Psychiatry	
Providers with less than 10 claims	
Providers who are new to HHP in 2024	

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