

Hawai'i Health Partners News

July 2015

Quality & Costs Must Go Hand in Hand

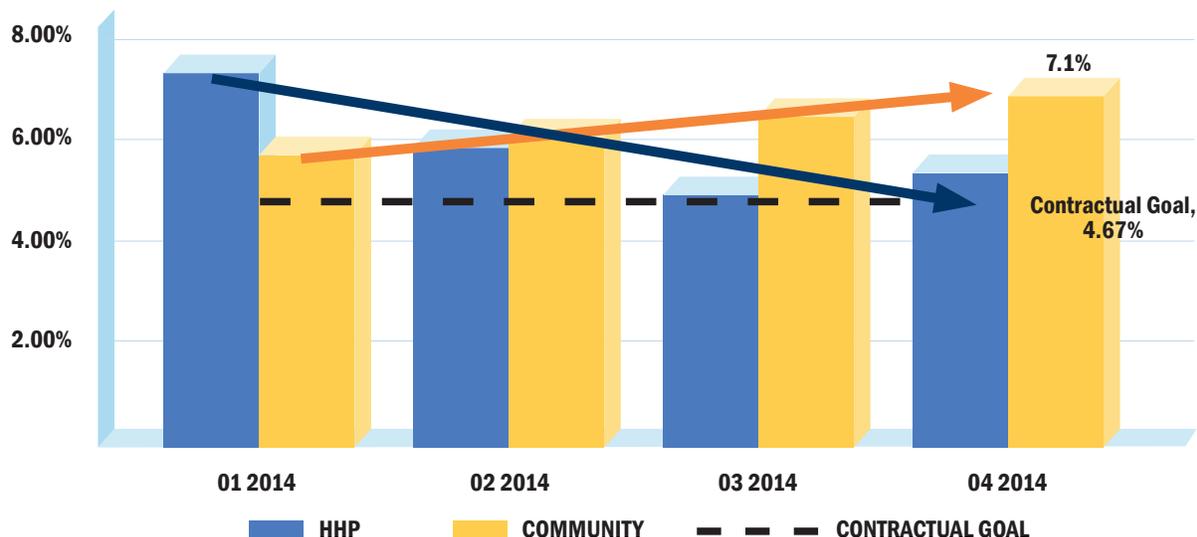
Let's talk about our ACO performance—particularly around costs. I hope it's no surprise to you that, as an ACO, we are accountable for both the quality and cost of care. Medical costs matter, not just because they are in our contract with HMSA—and almost certainly in any other contract we enter into over the next few years—but because without slowing down costs, we're harming patients.

Think that is overstated? Consider the effect that high premiums and copays have on patients accessing and adhering to care. A study by Harvard Law School in 2007 identified that approximately 62% of all personal bankruptcies were caused by unpaid medical expenses. Consider further that private and public subsidy of health care comes at the expense of other programs—

from pensions to parks, education, roads, police, and everything in between.

HHP's Medical Cost Trend (MCT) for the HMSA commercial population for 2014 was 5.3%, versus a national average of 6%. That's good, but is a bit like comparing apples to oranges, since that national average is dominated by Medicare costs, and HHP does not currently include Medicare. The more important comparison is against our 2014 contractual goal with HMSA of < 4.67%, against which we fall just short (before you draw any conclusions about what happened during the year, you've got to know the confounders, and there are several). The good news is we budgeted with the expectation that it would take more than one year to reach this goal.

**Comparison of Medical Cost Trend
(raw, NOT severity adjusted)**



Hawai'i Health Partners (HHP) members who use Epic through Hawai'i Pacific Health or HealthAdvantage CONNECT have a variety of new features available for use with the recent Epic upgrade. The changes are designed not only to make physicians' jobs easier, but also to improve the quality of care for patients.

Studies show that when health care providers have access to complete and accurate information, patients receive better medical care. Electronic health records (EHRs) can improve the ability to diagnose diseases and reduce—even prevent—medical errors, improving patient outcomes.

According to a national survey of physicians¹:



Report that their EHR makes records readily available at point of care.



Report that their EHR produces clinical benefits for the practice.



Report that their EHR allows them to deliver better patient care.

“The Epic upgrade is benefitting users by providing a faster workflow with more customizable options, more patient information quickly and easily accessible via InBasket (IB) messages and Sticky Notes, and a streamlined and more intuitive design for screens like IB and medication warnings,” says [Robyn Polinar](#), Health Advantage CONNECT supervisor.

To address the MCT, we've put these three major initiatives in play in the last year:

- 1. COMPLEX CARE:** Initially, we had great expectations about providing more effective, efficient care to our complex patients, using a 3rd party vendor. Our vendor had been successful with a similar project on the Big Island, but sadly, it didn't turn out to be nearly as successful here. We've closed that chapter and are now applying the lessons learned in pilots with various PCPs.
- 2. PATIENT CENTERED EMERGENCY ACCESS (a.k.a. Potentially Avoidable Emergency Department Visits):** Roughly one in three ED visits appear to be for reasons that might have been more appropriately treated in a primary care office or urgent care clinic. We've used that knowledge to guide our efforts to help patients access more appropriate care in more appropriate settings, and the percentage of potentially avoidable ED visits decreased from 36.5% in October 2014 to 35.5% in February 2015.
- 3. HIGH INTENSITY DIAGNOSTIC IMAGING AND CHOOSING WISELY:** Starting in November 2014, we started to turn on Choosing Wisely alerts in Epic. This decision-support program only fires when it appears that an order is being written that might be harmful and/or wasteful. There are 127 such rules, and many are related to unnecessary use of diagnostic imaging.

HHP has had a very good first year—we've grown our population to the critical mass needed to be effective in population care (presently about 87,000 members), built the infrastructure to understand the needs of the population that we serve, and found ways to help ease the load for Primary Care. It's still early, but our quality performance was very good—highest marks ever in Ambulatory Quality, and good enough quality in Inpatient Quality to distribute a bonus under our Quality Performance Program—and our clinically-driven approach to improve costs looks promising.

We've been very forward with our claims to be physician-driven. If we aim to succeed with this physician-driven approach, we'll need you. Please make the effort to understand and support the clinical programs that we're bringing about, and, if inclined, please take advantage of the opportunity to join a clinical workgroup. There are only a few low hanging fruit; all sorts of help is needed to reach the many clinical topics ripe for improvement. If you're reading this, you are part of a vital, forming community. We're glad to have you onboard.

MEASURE OF THE MONTH:

Honoring POLSTs at the Hospital

The percentage of Included Patients with a completed POLST upon presenting for care, who had their POLST wishes honored while receiving services at an HPH hospital.

INCLUSIONS

Included Patients shall be any patients who present for care at an HPH hospital either with a completed POLST in Epic, OR for whom a completed POLST is provided by the patient, EMS, a family member, or other individual. Included Patients will be any patients with POLST who expired in ER and all observation and inpatient admissions.

Honoring POLSTS at the Hospital (continued)

ELIGIBLE PHYSICIANS

An Eligible Physician shall be any physician who orders POLST-related care within 12 hours of arrival for at least five included patients during the calendar year:

- **Attending physicians**
- **Emergency Department physicians**
- **Hospitalists**
- **Geriatricians**
- **Palliative Care physicians**
- **Intensivists**

TARGET

100% = 1 point

Must be completed on 100% of included patients to get any credit. No “partial credit” is possible.

CLINICAL GUIDELINES:

- Code status orders should be reflective of the patient’s POLST orders when reviewed on admission.
- Physicians need to document that POLST discussion was reviewed with patient, their Health Care Power of Attorney, or family.
- Acknowledge the BPA for POLST then document in the ACP problem list and/or the ED, H&P, and/or progress notes.

Documentation Required (2 Advisories)

 **POLST on file - enter the POLST review order**

Acknowledge reason:  

Initiating Recommendation

Will evaluate patient

Will notify primary care team

Open order. POLST REVIEWED

PRACTICAL TIP:

If DNR is checked in Section A of the POLST and the patient is hospitalized, it is important to establish the goals of care in Section B (Medical Interventions). Medical Interventions are separate from their wishes for resuscitation in the event of cardiac arrest.

E.g., a patient has a POLST with DNAR (Do Not Attempt Resuscitation) in Section A and Full Treatment in Section B. If the patient agrees with the POLST upon review, the code orders may either be partial code or DNR orders in Epic, and all other medical interventions, including ICU care and intubation, will be consistent with this patient wishes. If the patient and/or their health care power of attorney/family disagrees with current POLST, document the discussion in your notes. This patient will benefit from a new POLST.

EXCLUSIONS

Patients shall be excluded from this measure if the POLST is provided to the Eligible Physician after care has been initiated (e.g., if the POLST form requests no cardio-pulmonary resuscitation, but the resuscitation is initiated prior to the information being provided to the Eligible Physician) or if the patient is discharged from the ED.

CLINICAL GUIDELINE:

Review POLST link on the patient’s header and/or advance care plan (ACP) file documents located in your physicians navigator or snapshot in Epic.

Honoring POLSTs at the Hospital (continued)

POLST Location and BPA

The screenshot displays a medical chart interface. At the top, patient information includes MRN: <30000070>, Room: None, DOB: 04/16/1944 (70 yr old/F), Ht: None, BSA: None, Iso: None, Allergies: Unknown: Not on File, Admin Date: None, and FYI: FYI. The chart is titled 'Acp. Training' and 'POLST received'. The main content area is divided into sections: 'Demographics' (70 yr old female, Comm Pref. None), 'Problem List' (Stroke due to intracerebral hemorrhage, POLST (Physician Orders for Life-Sustaining Treatment), Colonectal Cancer, stage IV, ACP (advance care planning)), 'Advance Care Plan Documents' (Advance Directives and Living Will dated 04/10/14 0638, POLST dated 04/10/14 1490), 'Allergies' (Not on File), and 'Medications' (None). A sidebar on the left contains navigation options like Chart Review, Flowsheets, Results Review, Allergies, History, Problem List, Demographics, and Letters.

PRACTICAL TIP:

DNR does not mean “do not treat.” Instead of talking about DNR, use the term DNAR (Do Not Attempt Resuscitation). It means if that patient’s heart stops, allow natural death.

For more information, including more helpful screenshots, see p. 20 in the 2015 Program Guide for Physicians.

Questions or comments about this measure? Best practices to share? Email HHP Marketing Manager Brian Driscoll at brian.driscoll@hawaiiipacifichealth.org to share with the HHP team.

PRACTICE PRIMER:

Colon Cancer Screening

Routine screening is the key to preventing colorectal cancer. The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer, beginning at age 50 and continuing until age 75, using:

- **HIGH-SENSITIVITY FECAL OCCULT BLOOD TEST (FOBT):** should be done every year
- **FLEXIBLE SIGMOIDOSCOPY:** should be done every five years with FOBT every three years
- **COLONOSCOPY:** should be done every 10 years—colonoscopies can be used as screening tests or as follow-up diagnostic tools when the results of another screening test are positive

While screening for patients with average risk should be done every 10 years, beginning at age 50, patients at higher risk of developing colorectal cancer should begin screening at a younger age and may need to be tested more frequently.

Individuals considered high risk, requiring enhanced screening and/or surveillance, include those with:

- Personal history of colon cancer—screening begins one year post resection followed by three years, and then every five years thereafter
- Familial history of colon cancer, including:
 - colorectal cancer or adenoma in first degree relative (i.e. mom, dad, brother, sister) less than 60—screening begins at age 40 or 10 years earlier than age of the youngest first degree relative at diagnosis (whichever is first) then five years subsequently
 - colorectal cancer or adenoma in first degree relative or two or more first degree relatives with colorectal cancer or adenomas greater than 60 years of age—screening begins at 50 and every 10 years subsequently

Practical Primer: Colon Cancer Screening (continued)

- History of adenoma—screening every five years
- African American ethnicity—screening begins at age 45
- Complex polyp noted in path report (serrated, villous, more than three adenomas, dysplasia, and adenomas greater than 10mm)—should be directed to physician or PA for further review
- Genetic syndromes, ulcerative colitis, Crohn’s—should be referred to physician or PA prior to scheduling

The decision to be screened after age 75 should be made on an individual basis. For more information, read the current colorectal cancer screening guidelines from the USPSTF.

HHP MEMBER SPOTLIGHT: Micheal H.T. Sia, MD



Michael H.T. Sia, MD

Michael H.T. Sia, MD, MPH, FAAP, is a board-certified pediatrician practicing in Honolulu since 1994. He is an Associate Clinical Professor for the Department of Pediatrics at the University of Hawai‘i, John A. Burns School of Medicine, and Chairman of the Department of Pediatrics at the Kapi‘olani Medical Center for Women & Children.

Dr. Sia was born and raised in Honolulu, attending Punahou School. He graduated from Dartmouth College (Hanover, NH) and later received his medical degree from Case Western Reserve University (Cleveland, OH). He completed his pediatric training at the Stanford University Hospitals, serving as the Chief Resident at the Lucile Salter Packard Children’s Hospital at Stanford during his fourth and final year. Dr. Sia has a Master’s in Public Health from the University of Hawai‘i. Honored with the “Best Doctors in America” award since 2001, Dr. Sia’s interest in pediatric and public health education has enabled him to focus on sharing and facilitating clear and unbiased medical information with families about their children’s development and health.

Dr. Sia currently serves on various volunteer community service panels as a board member, health consultant, medical advisor, and clinical researcher.

HHP: What is the biggest challenge you face as a physician?

SIA: In the current health care environment, it is getting used to the internal and external forces that require physicians in private, independent practice to rethink our relationships.

We are being pushed and pulled in so many new ways—Accountable Care Organizations (ACOs) like HHP, which are intended to manage quality and cost of care of defined patient populations; new payment methodologies; financial incentives; and the need to deliver greater “value” in an increasingly competitive marketplace.

There is a more direct employment of physicians by hospitals. The bottom line is, if one considers engaging in a relationship with a hospital or health system, will one be able to still serve their patients and maintain that elusive balance of professional satisfaction and practice viability?

HHP: What inspired you to become a physician?

SIA: My father, Calvin Sia, MD. He is the “grandfather” of the medical home concept of care for children. I am proud to have his longstanding commitment to providing patient-centered care to children. He was an early patient-centered medical home pioneer who advocated for the model long before the concept was widely known.

HHP Member Spotlight: Micheal H.T. Sia, MD (continued)

HHP: How has Hawai'i Health Partners helped you and your practice to better serve patients?

SIA: Transparency has been the single essential issue that HHP has delivered on. Utilizing EPIC and enhancing communication with HMSA's Cozeva (while not perfect) allows me to have the necessary information and documents to guide my partnership.

As a PCP, PCMH Coordinator Maggie Martinson, her colleagues, and other support staff enable my solo practice to become less burdened by the overwhelming tasks required for effective care management, quality improvement, and HMSA PCMH/P4P programs. This allows for better clinical integration and care coordination for my HMSA patients.

HHP: Why do you think some physicians would be more reluctant to join an ACO?

SIA: It's the autonomy—some physicians are worried about marching to the beat of the organization's drum, instead of their own. But I've found that HHP has enabled me to maintain my independence while learning to be more efficient. It provides a level of support to my HMSA patients that I couldn't offer on my own.

We are in a different era. To survive, we must learn to work together and communicate. I've always fought for equity, balance, and transparency. Everyone needs to know what's expected of them, and the priorities have to rise above the obstacles.

HHP: As an HHP member, what are your short-term and long-term goals?

SIA: My short-term goals are to create and maintain the concept of the "team care" approach. To be collaborative with my colleagues and create an environment where my care is delivered more efficiently and effectively, improving my satisfaction and sanity, as well as positively impacting patient care and, hopefully, costs. My long-term goals are to deliver "high quality care" for optimal patient health, with the economies of scale to support Hawai'i Health Partners, and to enjoy the practice of pediatric medicine.

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:

- **James T. Kakuda, MD**, Surgeon, Pali Momi Medical Center
- **Andrea L. Parker, NP**, Pediatric Nurse Practitioner, Kapi'olani Medical Center for Women & Children

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