HAWAIʻI HEALTH PARTNERS
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HAWAIʻI PACIFIC HEALTH
Kapiʻolani · Pali Momi · Straub · Wilcox

Hawaiʻi Health Partners News

August 2015

Does Shared Decision Making Really Work?

Patient engagement is one strategy to achieve the "triple aim" of improved population health, better experience of care, and lower per capita costs; and shared decision making is one component of that. Shared decision making is a collaborative process that allows you and your patients to make informed decisions together, taking into account both medical evidence and their personal preferences.

This strategy is often used with patients who have "preference-sensitive" conditions or treatment options, meaning they may not choose particular treatment options or to even be treated at all, depending on their own feelings and the risks versus rewards.

Patients who are more actively involved in their care make very different decisions with lower costs—there is growing evidence to support this. Still, some continue to question the effectiveness of shared decision making. Is there any evidence that shared decision making leads to different actual outcomes? The answer, although still early, is "yes."

THE EVIDENCE

David Veroff and coauthors conducted one large randomized study involving patients with at least one of six different preference-sensitive conditions:

- **Heart conditions**
- **Benign uterine conditions**
- **Benign prostatic hyperplasia**
- **Hip pain**
- **Knee pain**
- **Back pain**

Veroff and his colleagues identified 60,185 of 174,120 people as those who could benefit from shared decision making. Of that group, 30,240 received "usual support," while 29,945 received "enhanced support"—meaning health coaches had telephone contact with a higher proportion of the group (22.8% vs. 7.5%) and provided more educational material, literature, and videos. This not only made the patients more aware of their conditions and the various treatment options, it also made them more active participants in their care.

Both groups included similar individuals with similar demographic characteristics, chronic conditions, risks, and overall resource use and medical expenditures.

The impact of shared decision making was significant. The rate of hospital admissions was lower in the enhanced support group for each of the preference-sensitive conditions—13.9% lower for heart conditions, 13.9% lower for benign uterine conditions, and 12.8% lower for back pain—and the enhanced support group had fewer advanced and standard imaging studies.

Total medical costs were also $23.27 (or 5.3%) per person per month lower in the enhanced support group

The Evidence (continued)

with lower per member per month costs in all six of the condition subsets except knee pain. For the heart condition subset, the enhanced support group had 8.7% lower costs than the usual support group.

This is one of several studies that support the potential effectiveness of shared decision making. It seems intuitive—invested, informed patients make different decisions than those without the same level of investment.

MEASURE OF THE MONTH:

Advance Care Planning in the Ambulatory Setting

Advance Care Planning (ACP) is a structured discussion with a patient and/or his or her representative about the patient's health care choices that results in the documentation of the patient's end-of-life instructions. This includes a process that makes the documentation available to all who will participate in the patient's treatment.

Research indicates most patients have NOT participated in ACP, yet many are willing to discuss end-of-life care. Physicians are in the best position to have this discussion with patients, and studies have shown it can lead to increased patient satisfaction, less fear and anxiety about end-of-life care, and a stronger belief that their physicians were respectful of their wishes.

DESCRIPTION: The percentage of included patients who had an advance care plan and/or an ACP discussion with their PCP and the plan or discussion is documented in the patient's medical record

ELIGIBLE PHYSICIANS: Adult PCPs as defined by the HMSA 2015 PCMH Adult program

RELATED SPECIALTIES:
- Internal Medicine
- Family Medicine

TARGET:

≥80%	=	1 point (max)	≥20%	=	.5 point
≥25%	=	.75 point	≥15%	=	.25 point

INCLUSIONS: Included patients shall be attributed patients 75 years of age and older

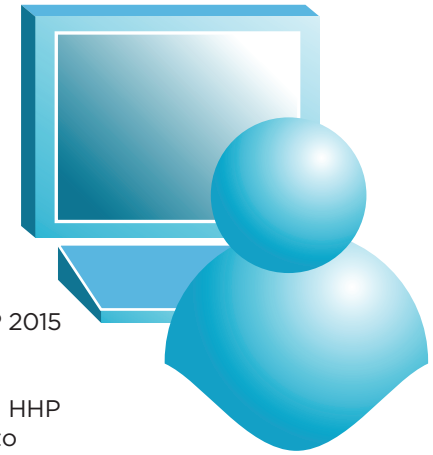
EXCLUSIONS: A patient shall be excluded from this measure if the patient's culture and/or spiritual beliefs preclude a discussion of ACP (CPT Code 1124F)

PRACTICAL TIPS:
Important to use the accurate CPT code for the ACP credit.

CPT CODE	DESCRIPTION
1157F (Documentation)	Advance care plan or similar legal document present in the medical record
1158F (Discussion)	Advance care plan discussion document in the medical record
1124F (Exclusion)	Advance care plan discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Documentation regarding decisions/discussions on ACP—especially any new updates—should be noted in the visit note and also on the ACP problem list.
For CPT codes, type in "ACP," use the specific CPT code, or use the ACP Clinic Smartset.

How Do ACP Forms Get Scanned Into Epic?



- **Staff to FAX to Medical Records**
- **Do not scan from clinic department!**
- **Medical Records will scan within 24 hours**

For more information, including more helpful screenshots, see p. 23 in the HHP 2015 Program Guide for Physicians.

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

IT Corner:

New Discharge Alerts Help Eliminate Gaps in Care

Ensuring the accuracy and timeliness of patient information is always a challenge, but HHP members have now been equipped with another tool to help ensure continuity of care and initiate appropriate follow-up care.

As of May 28, 2015, physicians using Epic began receiving hospital discharge alerts for their patients, allowing them to quickly react to patients' developing needs. "HHP puts physicians in the position to have all the tools they need to be aware and take action," says **Keoki Clemente**, Hawai'i Pacific Health's Director of Revenue Integrity. "These alerts ensure that there is no gap in care, and necessary and appropriate care coordination occurs."

"Feedback from PCPs revealed timely notification was needed to aid patients in the difficult transition from a hospital stay to home," says **James Lin, MD**, an HHP member and pediatric hospitalist at Kapi'olani Medical Center for Women & Children. "My role was to facilitate design, content identification, and execution of an automatic notification of an inpatient discharge to the PCP."

Upon discharge, the new feature identifies the patient's primary care physician and sends the alert via Epic Inbasket messaging or fax. This then triggers the follow-up. This timely communication helps ensure the best possible care for the patient during that critical time when many hospital readmissions can occur. It also ensures that physicians are able to provide, and bill for, timely care necessary for transitional care management. These services, along with their appropriate CPT codes, include:

CPT 99495 ($184.35 HMSA fee):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision making of at least moderate complexity during the service period
- A face-to-face visit within 14 calendar days of discharge

CPT 99496 ($259.58 HMSA fee):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision making of high complexity during the service period
- A face-to-face visit within seven calendar days of discharge

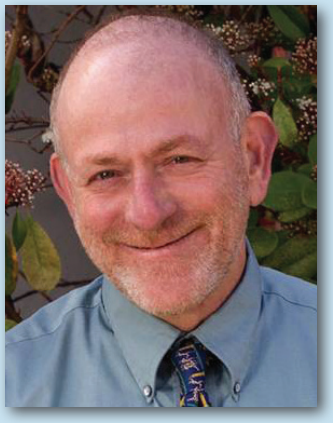
Join Us for Our Annual Meeting!

The HHP Board of Managers and administration invite you to attend the

HAWAIʻI HEALTH PARTNERS SECOND ANNUAL MEMBERSHIP MEETING

on Wednesday, September 30, 2015.

The meeting will be held from 5:30 to 8 p.m. at the Hawaii Prince Hotel Waikiki in the Mauna Kea Ballroom. Buffet dinner is included, and our featured keynote presenter will be **Alan Glaseroff, MD**, who will be sharing with us his design for better health care delivery.



Alan Glaseroff, MD

Dr. Glaseroff is co-director of Stanford Coordinated Care, a service for patients with complex chronic illness. Dr. Glaseroff, a member of the Innovation Brain Trust for UNITE HERE HEALTH, currently serves as faculty for the Institute for Healthcare Improvement's "Better Health, Lower Costs" collaborative and served as a clinical advisor to the PBGH "Intensive Outpatient Care Program" CMMI Innovation Grant that was completed in June 2015. He has served on the NCQA Patient-Centered Medical Home Advisory Committee from 2009 to 2010 and the "Let's Get Healthy California" expert task force in 2012. Dr. Glaseroff was named the California Family Physician of the Year for 2009 by the California Academy of Family Physicians.

Dr. Glaseroff's interests focus on the intersection of the meaning of patient-centered care, patient activation, and the key role of self-management within the context of chronic conditions.

JOIN US FOR THE OPPORTUNITY TO:

- **Learn about the changing health care landscape in Hawaiʻi and how it will impact your practice.**
- **Ask questions about the organization and what's planned for the future.**
- **Network with members and exchange practice innovation ideas.**
- **Meet your Hawaiʻi Health Partners Board of Managers, administration, and support staff.**
- **Share in planning the future of your physician organization.**

For more information or to RSVP, contact us at conference@hawaiipacifichealth.org or call HPH Conference Services at 808-522-3469.