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HAWAIʻI PACIFIC HEALTH
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Hawai'i Health Partners News

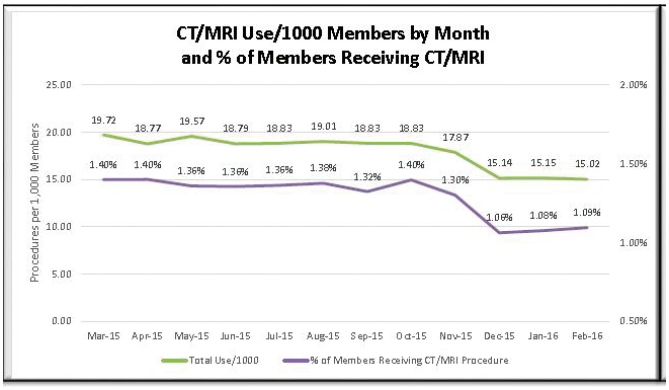
May 2016

Managing Appropriate Imaging – What's Next?

We can all acknowledge the current prior authorization process isn't perfect, to say the least. There is a lot of work to do in developing a more seamless approach for you and the patients you treat. To succeed with that, we need to better understand the problem we're facing.

First, as discussed in an **earlier article**, we need to look at the broader, national issues around inappropriate testing. But the next step is digging in and looking at our experience to date.

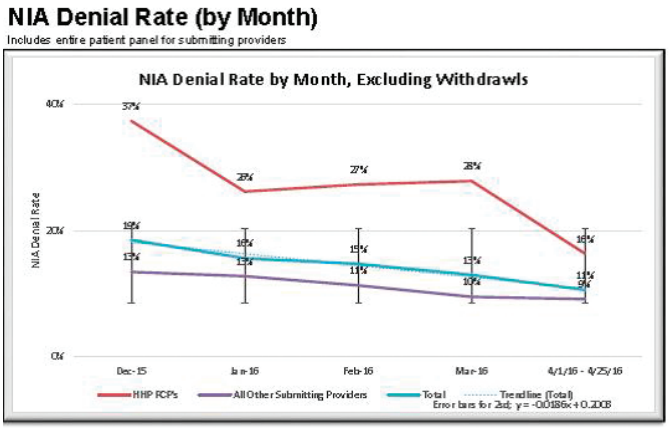
Take a look at where you fall in comparison to your HHP colleagues. The following captures imaging utilization by HHP members through February 2016:



HHP physicians averaged well over 1,400 total CT/MRI procedures per month (both in and out of network) through November 2015, at which point that number began to steadily drop to just over 1,200 procedures per month. We've gone from 19.72 procedures per 1,000 members in March 2015 to 15.02 procedures per 1,000 members in February 2016, or from 1.40 percent of our patient members to 1.09 percent. It's, of course, no coincidence that our drop in procedures directly correlates with the arrival of HMSA's preauthorization process, but the question to ask is whether we were managing diagnostic imaging appropriately.

Recognizing that National Imaging Associates (NIA) is not the best gold standard of appropriateness, it's the only broadly applied gauge we have. The NIA denial rate show improvement in rates of approved studies.

The NIA denial rate dropped significantly for HHP PCPs, from 37 percent in December 2015 to 28 percent in March 2016, with 1,264 approved procedures. For April, that denial rate dropped even more, to 16 percent as of April 25.



The Cost Issue

Not surprisingly, costs have dropped as the number of approved procedures decreases. For calendar year (CY) 2014 to 2015, the diagnostic radiology per member per month (PMPM) cost increased 7 percent from $14.25 to $15.32. Use per 1,000 patients also increased 7 percent during that time period. However, for January 2016, the PMPM was down 7 percent. For CY 2015, diagnostic imaging represented 5.3 percent of the claims spend. For January 2016, that number dropped to 4.8 percent.

A Physician-led Solution

To appropriately manage diagnostic imaging, we need to be the ones driving it. Here's an approach: first, look at why we're ordering tests and work together to identify and share best best practices. The top 30 diagnostic imaging diagnoses for HHP providers through February 2016 included the following:

#	Diagnosis Name	In Network	Out of Network	Total Procedures	% of Total
1	Headache	393	94	487	2.8%
2	Dizziness and giddiness	198	52	250	1.5%
3	Pain in joint, lower leg	116	114	230	1.3%
4	Abdominal pain, other specified site	182	29	211	1.2%
5	Calculus of kidney	147	61	208	1.2%
6	Other nonspecific abnormal finding of lung field	171	28	199	1.2%
7	Solitary pulmonary nodule	167	20	187	1.1%
8	Pain in joint, shoulder region	86	72	158	0.9%
9	Syncope and collapse	96	62	158	0.9%
10	Sepsis, unspecified organism	117	25	142	0.8%
11	Unspecified cerebral artery occlusion with cerebral infarction	107	34	141	0.8%
12	Calculus of ureter	103	32	135	0.8%
13	Head injury, unspecified	84	41	125	0.7%
14	Disturbance of skin sensation	101	22	123	0.7%
15	Unspecified septicemia	85	38	123	0.7%
16	Chest pain, unspecified	98	19	117	0.7%
17	Unspecified abdominal pain	91	25	116	0.7%
18	Abdominal pain, unspecified site	83	28	111	0.6%
19	Degeneration of lumbar or lumbosacral intervertebral disc	81	26	107	0.6%
20	Cervicalgia	70	32	102	0.6%
21	Lumbago	70	28	98	0.6%
22	Hematuria, unspecified	82	6	88	0.5%
23	Contusion of face, scalp, and neck except eye(s)	62	25	87	0.5%
24	Unspecified injury of head, initial encounter	64	23	87	0.5%
25	CONTUSION FACE/SCALP/NCK	62	25	87	0.5%
26	Pain in right knee	55	27	82	0.5%
27	Microscopic hematuria	75	7	82	0.5%
28	Other chest pain	56	26	82	0.5%
29	Malignant neoplasm of breast (female), unspecified site	66	13	79	0.5%
30	Urinary tract infection, site not specified	44	33	77	0.5%
	Top 30 Total	**3,212**	**1,067**	**4,279**	**25.0%**

As you can see, "headache" is the clear leader inviting us to standardize our approach to the diagnosis and management of this diverse set of patients.

Next, we should ensure that we are using the right appropriateness criteria. For example, some of our orthopedic, bone and joint, and radiology members raised concerns about the appropriateness criteria for sports hernia. An appeal to update the criteria has been accepted and will be implemented in the next few weeks.

Perhaps the most important part of our solution is our ability to work together, learn from each other and support our peers. By reviewing appropriateness scores, evaluating what is working for those with low denial rates, and working together to help those who need it, we can take control of the solution and eliminate the middleman.

Choosing Wisely

One tool currently in place is **Choosing Wisely**. The Choosing Wisely initiative encourages more conversations between you, your colleagues and your patients. The basic notion is to:

Ensure that an ordered procedure is necessary and appropriate. The referring physician and radiologist play key roles in this process. Make sure the imaging information will affect diagnosis or treatment and explain to your patient how you will use the information.

Avoid repeating tests unnecessarily. Checking the record for previous results (and asking the patient about results from other facilities) is an important, common sense measure. Ask the patient about previous test results; a test may have been performed elsewhere. Carefully weigh the utility and need for follow-up imaging.

Choose the correct procedure the first time. Specific to imaging studies, appropriate use criteria from the American College of Radiology are available online at **acr.org/Quality-Safety/Appropriateness-Criteria**.

The criteria are easy to use and cover a wide range of imaging procedures.

Educate the patient and family about the risks and benefits of a procedure. There are excellent patient education materials available as part of the Choosing Wisely platform that can be viewed online at **choosingwisely.org**. Some sites are exploring the use of these materials in the waiting room or exam room.

A Lot More Work to Do

As mentioned before, our partnership with HMSA must result in better jointly-developed solutions.

Our centralized process was a start and has hopefully decreased the administrative burden for our members while we've worked on a more permanent solution. It was a step in the right direction, but not nearly the solution we're looking for.

Another positive step will be a new pilot we will be launching in June that uses EpicCareLink to do the clinical chart review work for NIA radiology authorization. This will cut down on the back and forth, eliminating clinical questions and should improve the overall process. We will expand to additional physicians based on our experience, and will continue looking for more ways to reduce inappropriate imaging with minimal disruption.

Managing appropriate testing is the right thing to do for our patients and for our organization, but physicians need to be the ones driving it. Let's show a better way.

CKD Workgroup Update

Launched in August 2015, HHP's Chronic Kidney Disease (CKD) Workgroup has accomplished quite a bit in a short period of time. Led by Workgroup Chair Marti Y. Taba, MD, a Straub family medicine physician practicing in Kailua, the workgroup has distributed "heat maps" to all PCPs and developed a new HHP CKD Care Process Model that will be used in the coming months to educate PCPs on diagnosing and managing CKD.

Along with Dr. Taba, the group includes:

- Joseph Aoki, MD
- Melinda Ashton, MD
- Venkataraman Balaraman, MBBS
- Amy Corliss, MD
- Dale Glenn, MD
- Rhiana Lau, MD
- William Lee, MD
- Robin Matsukawa, MD
- Melanie Nordgran

- Kevin Takazawa
- Don Trailer, PA-C
- Ramona Wong, MD

In late 2015, the workgroup began providing multiple educational programs on CKD education and navigation – first, a onehour live CME session, followed by another one-hour virtual program and a 15-minute online learning module. The three educational programs together reached over 80 percent of HHP's employed primary care physicians.

In addition to the educational programs, the workgroup distributed CKD "heat maps" to all HHP primary care physicians and worked with the physicians to teach them how to use the "heat maps" to identify patients who may be at very high, high or medium risk for kidney disease, and how to more effectively manage those patients.

STEP 1A: DETERMINE LIKELY CAUSE OF CKD OR REFER IF UNCLEAR
STEP 1B: IDENTIFY RISK LEVEL BASED ON GFR AND ALBUMINURIA[1]

Prognosis of CKD by GFR and albuminuria categories: KDIGO 2012				Persistent albuminuria categories Description and range		
				A1	A2	A3
				Normal to mildly increased < 30 mg/g < 3 mg/mmol	Moderately Increased 30-300 mg/g 3-30 mg/mmol	Severely Increased > 300 mg/g > 30 mg/mmol
GFR categories (ml/min/1.73²) Description and range	G1	Normal or high	≥ 90			
	G2	Mildly decreased	60-89			
	G3a	Mildly to moderately decreased	45-59			
	G3b	Moderately to severely decreased	30-44			
	G4	Severely decreased	15-29			
	G5	Kidney failure	<15			

Low risk (if no other markers of kidney disease, no CKD)
Moderately increased risk
High risk
Very high risk

Lastly, the CKD Workgroup spent a good part of the year working on researching and developing a care process model for screening, identifying and managing patients at risk for CKD. The HHP CKD Care Process Model is currently in final review and will be distributed next month.The model will provide both screening and management algorithms, along with additional notes and resources.

Annual Meeting: Save the Date!

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

Measure of the Month: Blood Pressure Control

Description:

The percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement period based on the most recent blood pressure reading during the measurement period according to the following criteria:

18–59 years of age whose BP was < 140/90 mm Hg

60–85 years of age whose BP was < 150/90 mm Hg

Why this measure matters:

Untreated high blood pressure can lead to coronary heart disease, heart failure, heart attack, stroke, kidney damage, angina, peripheral artery disease and other serious conditions. According to the American Heart Association, 77 percent of Americans who've had a first stroke had high blood pressure at or over 140/90, while the same is true of 69 percent of Americans who've had a first heart attack. And 74 percent of Americans who have congestive heart failure have blood pressure levels above 140/90.

Best practice:

"It is just a question of diligence," says Charles Zerez, MD, an internist at Straub Clinic & Hospital who is consistently a top performer for this measure. "I try to make sure that everything is up-to-date every time I see the patient for any reason. This means that I look over everything, even when the patient comes in for an acute care visit." Zerez also makes sure to re-check the readings himself, he says. "That is really all there is to it."

For more information about how to achieve points on this measure, see page 25 in HHP's **2016 Program Guide for Physicians**.

Questions or comments about these measures? Email HHP Marketing Manager Brian Driscoll at **brian.driscoll@hawaiipacifichealth.org** to share with the HHP team.

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:

- Muhammad S. Ghumman, MD, Cardiology, Pali Momi Medical Center
- Mitchell T. Gudmundsson, MD, Diagnostic Radiology, Pacific Radiology Group, Inc.
- Jenelyn C. Lim, MD, Hospice & Palliative Care, Straub Clinic & Hospital
- Holly L. Olson, MD, OB-GYN, UCERA
- Sheldon Riklon, MD, Family Medicine, UCERA
- Donald A. Saelinger, MD, Gastroenterology, Straub Clinic & Hospital
- Timothy J. Swindoll, DO, Gastroenterology, Straub Clinic & Hospital
- Ike D. Tanabe, MD, Gastroenterology, Straub Clinic & Hospital
- Theodore H. Teruya, MD, General Surgery, Straub Clinic & Hospital