

# MEMBER NEWSLETTER

4th Quarter 2018

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## Letter from Our Vice President

Hawai'i Health Partners had a great year in 2017 and 2018. There were new record high level quality scores in both ambulatory and inpatient settings; in physician engagement with the largest physician event in HPH's history, O'ahu attendance climbed to 300 and Kaua'i to 85, shattering the previous year's record of 223 on O'ahu and 60 on Kaua'i. Total attendance was 385, a 36% increase from last year's 283. Adding to our successes, we earned funds under both the Quality Performance and Shared Savings Programs. With these kind of results, our patients are certainly benefiting from improved teamwork and coordination of the HHP network.

Additional benefits of our 2017 performance were bonus payments that many of you received for your specific contributions in the Quality and Shared Saving Performance Programs. Over \$3.5M was paid out in bonuses to 657 physicians for their 2017 performance. This reflects the partnership with HMSA demonstrated by the Accountable Care Agreement (ACA) between HPH, HHP and HMSA.

2018 is the last year of the five year ACA. As of January 2019, there will be a new agreement that will take the next step on the value based payment path. In the new

contract, it will be very important to make progress on the work underway to improve efficiency and increase appropriateness. Active examples include accelerated ambulatory pathways for conditions such as GI bleed, chest pain, preterm labor, use of care management and referral guidelines, and participation in small group discussions examining variation in care. Yet, there are so many more ways to improve care efficiency and effectiveness; they just need your help lead the way.

When our entire network is engaged in one or more of these initiatives, the combined effect is an outstanding and consistent care experience for patients. Physician engagement is the path to providing patients with affordable clinical excellence.

Thank you for your engagement and active participation in HHP. Your individual leadership and investment in HHP are the keys to our success.

Gerard Livaudais, MD, MPH, FACP  
Vice President | Hawai'i Health Partners

# 2018 Annual Meeting Q&A

A lot of voices were heard in this year's Q&A at the annual meeting. Below is the list of questions we received during the Annual Meeting that we were not able to cover in the Q&A sessions. In a few cases, we have consolidated multiple questions on the same topic and provided a summarized response. We have also made minor edits for clarity, to correct typos, and to remove inappropriate language. In addition, please note that we have removed comments and statements (positive or negative) where no actual questions were asked.

## Patient Self-Care

- What is your opinion on patient self-care accountability and providing patients with the tools to manage their care?

Patient engagement is important and has been shown to impact their care. Being aware of their health issues and receiving support from a coordinated team of health care providers establishes personal accountability. As self-management technologies such as MyChart empower patients to take a more proactive approach to self-care, self-care management practices will become an important part of health care delivery in the future. There are movements toward higher copays, high deductible plans and also reward programs for healthy behaviors. However, results are mixed.

## Specialist Survey

- How does the new specialist referral survey work?

The Specialist Referral Survey is an opportunity for specialists to earn HHP Shared Savings Program (SSP) points. To earn the SSP measure point, you need to have a minimum of five completed surveys by your HHP network referral base, by the time the survey closes on December 31, 2018. Earning the point is not based on your survey results, just completed surveys. The survey is not limited to a Primary Care Provider (PCP). Any provider, even a specialist, can complete the survey for the individual (i.e. a Neurologist can have a survey completed on by a Cardiologist).

To encourage honest and candid feedback, survey respondent identities remain confidential and their responses anonymous. As such, viewing individual referring provider survey responses is not an option. In addition, survey responses will be kept confidential and not be released to anyone other than the specialist selected in the survey. HHP leadership and staff, HPH leadership – i.e. CMOs, section/department chief will not see the results.

## ED Admission

- How can I prevent attendance to ED by patients who are sent away?

If patients are not being seen in another setting, they'll go anywhere they can be taken care of. Reducing ED visits is helped by being proactive with patients who suffer from multiple medical conditions via HHPs Complex Care services, and by rapid follow-ups with patients who have a high risk of return visits.

**Tools & Resources:** Regularly check your HHP PCP Dashboard for performance target status (avoidable visits 31% of total ED visits) and your patient care opportunity report.

## Healthcare Technology

- With our increasing focus on medical cost trend, how can we stay at the leading edge of technology in medicine?

There is an irreducible cost of care that technology (and inflation) will trend upwards as long as society is willing to pay for the benefits it brings. Being at the leading edge means knowing where the trade off is acceptable to patients and purchasers for new technology and treatments (e.g. new, extremely expensive cancer drugs) and disruptive innovation.

Disruptive innovation catalyzes change and transforms industries. On the frontlines of health care, HHP encourages and cultivates the open expression of ideas and those that seek out more efficient, effective solutions via clinical workgroups.

*Continued on page 3*

We will consistently provide opportunities to directly engage with leadership and each other in crafting these solutions.

## Capitation and Healthcare

### Related Questions:

- How will specialists be reimbursed under a capitated payment model?
- Is compensation for work completed in an administrative capacity a possibility?

Successful models of compensation such as "contact capitation" have a method of paying specialists that seems to be effective. The offset to a drop in volume (defined as use per thousand patients) is to serve a larger population and limit the number of specialists.

Specific compensation for administrative work depends on what kind of administrative work it is and the related payment arrangement. For example, a telehealth visit with a patient that the physician receives a "per member per month (pmpm)" payment for would probably be included in the pmpm payment.

## Administrative Burden

### Related Questions:

- What is being done to integrate and capture data more efficiently, and improve attribution of patients to PCP?

HHP is working independently and with HMSA to reconcile the discrepancies being seen in attributed lives and to find a sustainable, permanent solution.

## Healthcare Administration

### Related Questions:

- What are the (financial) goals for ASC use and how will that change surgical utilization?
- How does medical direction, other docs, work with 'non-physicians' i.e. health care administration?

ASCs provide the same quality of care at the appropriate location and cost. The goal is to begin using the ambulatory surgery centers (ASC) more appropriately for certain procedures. The volumes initially are not expected to be huge, but definitely noticeable.

During his presentation, "Beyond," HPH CEO, Ray Vara reinforced that HHP is physician-led and managed by medical professionals in the industry. He also spoke to physician-administration partnerships with the goal of more collaboration in the delivery of quality and efficient care to our patients and community.

## Accelerated Ambulatory Pathway

### Related Questions:

- Does this program work when patients are coming from another facility i.e. Kapi'olani Medical Center, Pali Momi Medical Center, Wilcox Medical Center?
- Is it required for Straub hospitalists to call the GI clinic for patient admissions?
- Is there an impact on inpatient census/revenue? How can engagement be leveraged to create cost savings?

This program is a site specific process. Transferred patients could still benefit from the process, if a collaborative agreement has been made with the site. Hospital operations, policy and agreements are under the direction of the hospital and their medical staff.

The goal of the AAP is to deliver the right care, in the right setting and at the right time. Provider engagement is the driver for quality, efficient care and cost savings.

# New & Noteworthy

## Taking the Lead: Developing an Effective Clinically Integrated Network

At this year's annual meeting, Hawai'i Pacific Health (HPH) CEO, Ray Vara shared that the landscape of health care showed signs of shifting to include new players, disruptive innovators such as Amazon, JPMorgan Chase and Walmart. Hawai'i Health Partners is aligned with HPH, has sought to manage our own self-disruption, focus on the knowledge and expertise of our members, but also on the ways in which both members and clinical leaders could take on the complexities of health care transformation. As a result, the phrase transforming healthcare has loomed over all of HHP as the guiding beacon to all that we do.

A cornerstone of our transformation is the development of a clinically integrated network, - the provider network arm of the ACO. An effective network requires strong physician leadership, interdependence and care coordination.

### Physician Leadership



The 2018 edition of the Care Management and Referral Guidelines is the first document of its kind for Hawai'i Health Partners. Its creation was catalyzed by HHP physicians and championed

by clinical leaders, has been established to address quality and appropriate care by reducing unnecessary variation, and other forms of waste or inefficiency.

Developing and producing a broad and beneficial document required strong physician engagement and collaboration between physician leaders, primary care providers (PCPs) and providers in other specialties.

The end product is a good example of what is possible with good teamwork and clinical leadership across specialties.

### Network and Care Coordination

In this year's annual meeting, three questions were asked during the roundtable discussion.

- What does an "Effective Network" mean to you?
- How do we achieve an effective network?
- Why is working within your Accountable Care Organization (ACO) provider network important?

*An effective network is one that communicates.*

The group consensus landed on 3 themes:

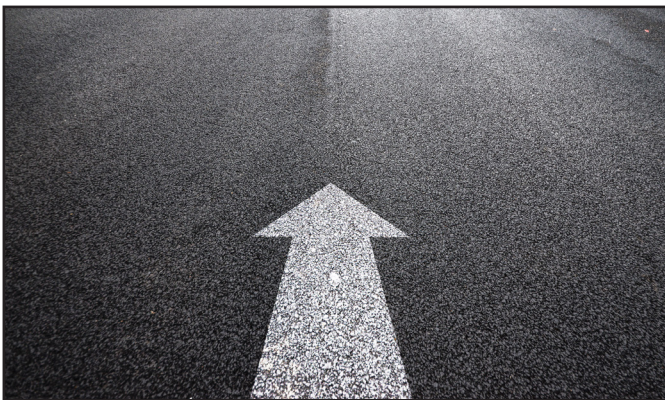
- "An effective network is one that communicates."
- "Collaboration is needed to achieve an effective network."
- "It is important to communicate and collaborate with one another within the ACO provider network, which improves care coordination and creates a connected patient experience."

*Continued on page 5*

# Taking the Lead...continued

## The Road Ahead

Hawai'i Health Partners has a clearly defined vision of what's needed for disruptive innovation to succeed with value based payment. The foundation has been laid. There is a clear and expanding physician leadership providing a strategic direction. The Care Management and Referral Guidelines (CMRGs), and creation of accelerated ambulatory pathways are changing how improve our quality, efficiency, and timeliness of patient care.



The most important part of all is broad-based, physician member engagement. Being a part of Hawai'i Health Partners means having the opportunity to directly influence health care delivery locally - in your practice, and "globally" – in our combined efforts as a network. Take the lead on addressing areas of opportunity for improved efficiency, appropriateness, and/or supporting outcomes for your patients.

## Key Foci:

- Social and clinical interconnectedness: Know who is in your ACO network and build a quality network with the support of tools such as the HHP Network Resource List and engagement opportunities such as clinical workgroups, clinical integration committees, the annual membership meeting, annual membership survey, specialist survey, board of managers' election, and member meetings.
- Improving access and quality of specialty care: Make use of clinical protocols such as the HHP CMRGs to optimize and enhance patient experience, clinical outcomes and efficiency.

The guidelines ask providers to appropriately consider when a specialist should be involved in the care of the patient. The intent for their use is as general guidance to practicing clinicians, which may change with time, and are not intended to supersede the medical judgment of the clinician.

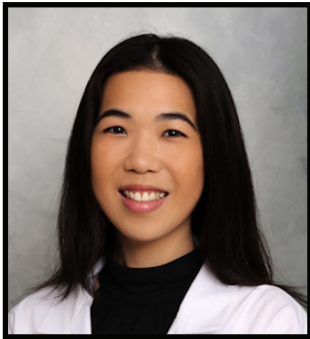
### Current List of Departments with Referral Guidelines:

- Adult Specialty
- Obstetrics and Gynecology
- Pediatric Specialty
- Behavioral Health
  - Adults
  - Pediatrics



# Looking For a Specialist?

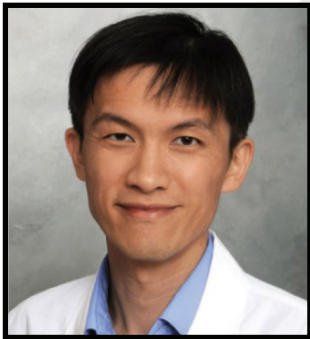
## Meet the HHP Rheumatologists



**Tracie Kurano, MD**

**Office Location:** Straub Medical Center – Makai Building, 3rd Floor | (808) 522-4522

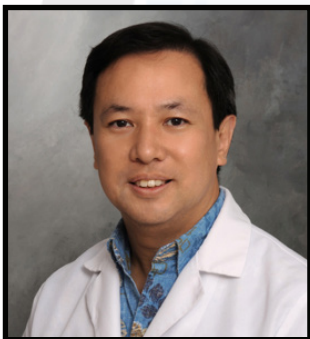
**Special Interests:** General Rheumatology, Gout, Inflammatory muscle diseases.



**Sian Yik Lim, MD**

**Office Location:** Straub Pearlridge (Primary), Straub Medical Center – Makai Building, 3rd Floor (Wednesdays), Kailua Medical Clinic (every other Friday) | (808) 522-4522

**Special Interests:** Osteoporosis, Gout, Rheumatoid arthritis.



**Alberto Santos-Ocampo, MD**

**Office Location:** Straub Medical Center, Makai Building, 3rd Floor | (808) 522-4522

**Special Interests:** Lupus, Rheumatoid Arthritis, Vasculitis, Psoriatic Arthritis, Gout



**Alan Oki, MD**

**Office Locations:** Pali Momi Medical Center (Mondays, Wednesdays, Fridays) | (808) 888-8875; Kuakini Medical Center, Ste. 490 (Tuesdays, Thursdays) | (808) 532-2050

**Clinic Contact:** Shannon Nakasato

**Special Interests:** Rheumatoid arthritis, systemic lupus erythematosus and other inflammatory connective tissue diseases with an emphasis on effects of diet, exercise, and psychosocial stressors on disease activity; brain and spinal cord complications of rheumatologic diseases.

# Due by Dec 31st! HHP Learning Modules

All 4 learning modules are available for completion. Click the link below to access them.

Learning Module 1: Perioperative Surgical Home

Learning Module 2: Clinical Decision Support

Learning Module 3: HPH Approach to Opioid Issues

Learning Module 4: Cervical Cancer Screening Guidelines

[healthstream.com/hlc/hph](http://healthstream.com/hlc/hph)

## Forgot Your Password?

Click the 'forgot password' link or contact IT Service Desk at (808) 535-7010 for password reset assistance.

## Forgot Your User ID?

Contact Michelle Zippay or Lori Watanabe at [michelle.zippay@hawaiipacifichealth.org](mailto:michelle.zippay@hawaiipacifichealth.org), (808) 522-0062 or at [Lori.Watanabe@hawaiipacifichealth.org](mailto:Lori.Watanabe@hawaiipacifichealth.org), (808) 535-7499.

## Experiencing Technical Issues?

Employed Providers: Call the IT Service Desk at (808) 535-7010.

Independent Providers: Contact Healthstream 24-hour customer service directly at 1 (800) 521-0574.



## Learning Module #4: CERVICAL CANCER GUIDELINES

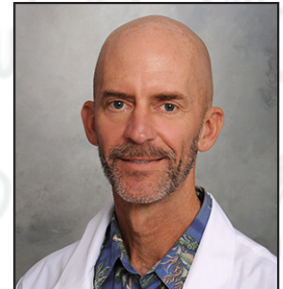
Jeffrey Killeen, MD  
Internal Medicine

## Learning Module #1: PERIOPERATIVE SURGICAL HOME



Matthew Nims, MD  
Anesthesiology

## Learning Module #2: CLINICAL DECISION SUPPORT



Mark Baker, MD  
Emergency Medicine

## Learning Module #3: HPH APPROACH TO OPIOID ISSUES



Melinda Ashton, MD  
Pediatrics



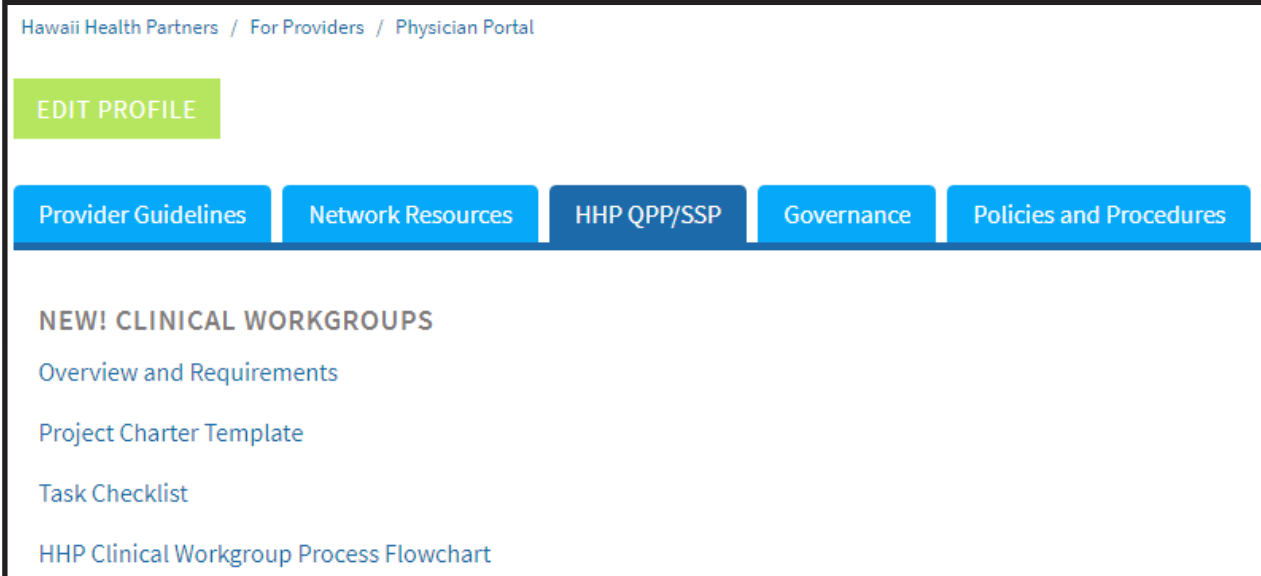
Bennet Loui, MD  
Internal Medicine

Not pictured: Jennifer Dacumos, PharmD, MBA  
Pharmacy Director

# Now Available! HHP Clinical Workgroup Materials

The 2018 Program Guide measure, "Participation in HHP Clinical Workgroups" is carrying over to the 2019 Program Guide. Chartering a workgroup requires approval from the HHP Quality and Clinical Integration Committee.

Download the workgroup materials. Additional information is available in last quarter's newsletter [HERE](#).



Hawaii Health Partners / For Providers / Physician Portal

[EDIT PROFILE](#)

[Provider Guidelines](#) [Network Resources](#) [HHP QPP/SSP](#) [Governance](#) [Policies and Procedures](#)

**NEW! CLINICAL WORKGROUPS**

- [Overview and Requirements](#)
- [Project Charter Template](#)
- [Task Checklist](#)
- [HHP Clinical Workgroup Process Flowchart](#)



## HHP Patient Measure Highlight (PCPs Only) Cervical Cancer Screening

Every seven minutes, a woman in the United States learns she has gynecologic cancer; cervical cancer, ovarian cancer, uterine/endometrial cancer, vaginal cancer and vulvar cancer – cervical cancer is the most common gynecologic cancer worldwide.

According to the American Cancer Society, screening procedures can help prevent cervical cancers by finding changes in the cervix before cancer develops, or in its early, most curable stage.

Historically, HHP has consistently performed above the 75th percentile nationally on Cervical Cancer Screening (see below graph). This year we are falling behind in closing our screening gap.

Please address the importance of cervical cancer screening (i.e. a pap test) with your applicable patients and encourage them to schedule an appointment either directly via your office or by calling 643-4DOC.

CERVICAL CANCER SCREENING		
HMSA Quality Measure		
<p>The percentage of attributed member women 24–64 years of age who were screened for cervical cancer using either cervical cytology during the measurement year or the two years prior.</p> <p>If age 30–64, a cervical cytology and a human papillomavirus (HPV) test with service dates four or less days apart during the measurement year or the four prior measurement years are also accepted.</p>		
<i>Eligible Providers</i>	<i>Line of Business</i>	<i>Performance Target</i>
<ul style="list-style-type: none"> <li>Internal Medicine</li> <li>Family Medicine</li> <li>General Practice</li> <li>Pediatrics</li> </ul>	HMSA Commercial  Quest  Medicare Advantage	<p>Members who were screened for cervical cancer using either of the following criteria:</p> <ul style="list-style-type: none"> <li>Members 24–64 years of age who had cervical cytology during the measurement year or the two years prior to the measurement year.</li> <li>Members 30–64 years of age who had cervical cytology and an HPV test with service dates four or less days apart during the measurement year or the four prior measurement years.</li> </ul> <p>The measure will use the billing codes from submitted claims to identify cervical cancer screening.</p> <p>Allowable numerator codes are available here:  <a href="https://hmsa.com/portal/provider/HMSA_Payment_Transformation_2018_Measure_Value_Set_Cervical_Cancer_Screening.pdf">hmsa.com/portal/provider/HMSA_Payment_Transformation_2018_Measure_Value_Set_Cervical_Cancer_Screening.pdf</a></p>

# HCC Coding Tip: Breast Cancer Awareness Month

## HCC w/RAF Score: (1) .672 & (12) 0154

Breast cancer is the second most common cancer for women in the United States. About 1 in 8 women will be diagnosed with breast cancer in their life; and although this occurs mostly amongst older women, about 11% of the new cases in the United States are found in women younger than 45 years of age. According to CDC's statistics on female breast cancer: "For every 100,000 women, 125 new female breast cancer cases were reported and 20 died from the cancer." With advancements in treatment the number of deaths have significantly decreased and there are about 3 million women living with breast cancer.

A hot topic when assigning an ICD-10 Neoplasm diagnosis code is whether the cancer is active or not. The interpretation of what is considered active versus history can leave a provider with more questions than answers.

ICD-10 CM Guidelines state: *"When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."* So what is considered "treatment" towards the site?

Generally, cancer is coded as current when the medical record clearly shows active treatment directed to the cancer and/or when the record notates the cancer is present but: 1) It is unresponsive to treatment, 2) The current treatment plan is observation only, or 3) The patient has refused any further treatment. According to the National Cancer Institute (NCI), active cancer treatment can also include adjuvant therapy which may consist of chemo, radiation, hormone, targeted, or biological therapy. Examples of drugs used as adjuvant therapy for breast cancer include Tamoxifen, Arimidex, Faslodex, and Femara. When adjuvant therapy is used, document the purpose (whether the goal of adjuvant therapy is curative, palliative, or preventative).<sup>1</sup>

When deciding whether to assign "history of" or "current" cancer diagnoses, it all comes down to documentation. Before selecting a diagnosis code one must ask, is the cancer still present, or is there "no evidence of the disease"? Is the patient still receiving adjuvant therapy; and if so, what is the purpose of that therapy? Clear, concise documentation to the highest level of specificity is required to ensure proper coding.

Tips on documenting: 1) Code the site of the cancer<sup>2</sup>, 2) Notation of whether it's current or historical<sup>3</sup>, and 3) Record your treatment plan.<sup>4</sup>

*Continued on page 11*

# HCC Coding Tip continued

(C50.-) Malignant Neoplasm of Breast <sup>5</sup> Examples of ICD-10 Diagnosis Code	
ICD-10 CM Diagnosis	Description
C50.411	Malignant neoplasm of unspecified site of right female breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C79.89	Secondary malignant neoplasm of breast
Z80.3	Family history of malignant neoplasm of breast
Z85.3	Personal history of malignant neoplasm of breast
Z12.31	Encounter for screening mammogram for malignant neoplasm of breast
Z17.0	Estrogen receptor positive status (ER+) Code first malignant neoplasm (C50.-)
Z79.810	Estrogen receptor negative status (ER) Code first malignant neoplasm (C50.-)
Z79.810	Long term (current) use of selective estrogen receptor modulators (SERMs)
Z79.818	Long term (current) use of other agents affecting estrogen receptors and estrógen levels

<sup>1</sup>Curative – to treat cancer, Palliative – to relieve symptoms and reduce suffering caused by cancer without effecting a cure, Preventative/ Prophylactic – to keep cancer from reoccurring or to prevent cancer from occurring in a person who is at risk due to family history or other factors.

<sup>2</sup>Document whether current breast cancer is primary, secondary, or in situ, laterality (left/right/bilateral), specific site, including location within the breast (areola, nipple, upper outer quadrant, central portion, etc.)

<sup>3</sup>If current, do not use “history of”; if historical, document under Impression a) no active treatment, or b) no evidence of disease or recurrence.

<sup>4</sup>Document a clear and concise treatment plan of care. If patient is still on current therapy, documentation must clearly state whether the therapy represents: 1) Active treatment of current breast cancer; or 2) Surveillance of a historical breast cancer to monitor for recurrence.

<sup>5</sup>a) 4th character identifies site: nipple/areola(0); quadrants(2-5); overlapping boundaries(8); unspecified(9), b) 5th character identifies sex: female(1); male(2), c) 6th character identifies laterality: right side(1); left side(2); unspecified (9)

# 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:

MEMBER	SPECIALTY	LOCATIONS
Edwin P. Herd, M.D.	Pediatrics	Hawai'i, Kailua-Kona
Matthew J. Haight, D.O.	Anesthesiology	Kaua'i, Lihue
Karsha I. Sathianathan, M.D.	Family Medicine	Kaua'i, Lihue
Ryan Christopher Yang, D.O.	Family Medicine	Kaua'i, Lihue
Rachel Ackerman, MD	Internal Medicine	Kaua'i, Lihue
Zaid Alirhayim, MD	Cardiology	O'ahu, Aiea
Jeong H. Kim, MD	Gastroenterology	O'ahu, Aiea
Jan T. Fujita, M.D.	Obstetrics & Gynecology	O'ahu, Aiea
Sarah P. Read, M.D.	Ophthalmology	O'ahu, Aiea/Kuakini
Heather E. Enomoto, M.D.	Emergency Medicine	O'ahu, Honolulu
David Worthen, MD	Family Medicine	O'ahu, Honolulu
Tanya K. von Detton, M.D.	Family Medicine	O'ahu, Honolulu
James O'Brien, MD	Gastroenterology	O'ahu, Honolulu
Jeremy Kort, MD	Internal Medicine	O'ahu, Honolulu
Christie H. Izutsu, M.D.	Nephrology	O'ahu, Honolulu
Shiuh Feng Cheng, M.D.	Nephrology	O'ahu, Honolulu
Teresa M. Bane-Terakubo, M.D.	Pediatrics	O'ahu, Honolulu
Alexandra G. Takayesu, M.D.	Psychiatry	O'ahu, Honolulu
Valerie Cacho, MD	Sleep Medicine	O'ahu, Honolulu
Ricky N. Amii, M.D.	Emergency Medicine	O'ahu, Honolulu/Aiea
Michele Y. Pangilinan, M.D.	Obstetrics and Gynecology	O'ahu, Honolulu/Aiea
Wanee G. Gomez, M.D.	Emergency Medicine	O'ahu, Honolulu/Kailua/Kaneohe/Mililani/Pearl City
Gerard F. Livaudais, M.D.	Internal Medicine	O'ahu, Honolulu/Kailua/Kaneohe/Mililani/Pearl City
Lydia Rolita, MD	Family Medicine	O'ahu, Mililani





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CREATING A HEALTHIER HAWAI'I

Questions? Contact us at [Info@hawaiihealthpartners.org](mailto:Info@hawaiihealthpartners.org)

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