2023

PROGRAM GUIDE

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

CREATING A HEALTHIER HAWAIʻI

CONTENTS

LETTER TO COLLEAGUES 3

PROGRAM GUIDE FOR PROVIDERS

Overview 4

Quality Performance Program 4

Shared Savings Program 4

Individual vs. Group Provider Participation 4

Measurement Period 4

POSSIBLE POINTS BY SPECIALTY

Quality Performance Program (QPP) 5

Shared Savings Program (SSP) 9

QUALITY PERFORMANCE AND SHARED SAVINGS PROGRAM

Quality Performance Program (QPP)

Criteria for Receiving Incentives 12

Shared Savings Program (SSP)

Criteria for Receiving Incentives 12

MEASURES IN BOTH QPP AND SSP

Attendance at HHP Annual Membership Meeting 14

Attendance at HHP Webinars 15

Participation in HHP Clinical Workgroups & Committee Leadership 16

QUALITY PERFORMANCE PROGRAM MEASURES

Avoidable ED Utilization 20

Hospital Acquired Harm 23

Medication Reconciliation Post Discharge 24

Sepsis and Septic Shock: Management Bundle (Composite Measure) 26

Vermont Oxford Network (VON) for VLBW and Expanded Database Measures. 28

Shared Savings PROGRAM MEASURES

Increasing Ambulatory Surgery Center Use 30
Mammogram Imaging Callback Rates 32
Postpartum Care 34
Specialty to Primary Care Patient Transition 35
Use of High-Risk Medications in the Elderly 37

LETTER TO COLLEAGUES:

Thank you for being a member of Hawai'i Health Partners (HHP). At HHP, we are your partner in providing high-quality care for your patients and are here to support your success.

The 2023 Program Guide was made possible by and is the result of the collaborative efforts of the HHP Finance and Quality & Clinical Integration Committees, Metrics Subcommittee, the physician-led HHP Board of Managers, HHP administration, and the membership at large.

This year's Program Guide continues to focus on the delivery of quality care to our patients and achieving success in our implementation of value-based health care.

As we enter the second year of our five-year agreement with HMSA, we will continue to evaluate and adjust our measures in our Quality Performance and Shared Savings Programs (QPP/SSP) to ensure they are the right areas of focus for both you and our patients. You will see this reflected in the measures established for 2023 and outlined in this guide, as we removed some measures, made adjustments to measures, and added new measures.

These measures support our continued focus on effective care coordination, providing the highest quality care while improving cost of care delivery, incorporating more efficient processes, and our ongoing transition from fee-for-service to value-based care.

HHP member engagement and participation in the QPP/SSP program continues to grow. We look forward to rewarding and recognizing your commitment to delivering value-based care following the completion of the 2023 program year.

Our HHP team is here to support you through this time of reemergence and our journey toward health care transformation. Thank you for all you do for our patients, our organization and our community.

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 two performance programs – the Quality Performance and Shared Savings Programs – with potential for incentive payments. Each has unique characteristics and methodologies for how the programs are funded and rewards are distributed.

Quality Performance Program

The Quality Performance Program (QPP) is designed to engage and recognize providers who contribute to achieving quality performance goals in the inpatient setting benefitting the care of HHP's attributed members.

Shared Savings Program

The Shared Savings Program (SSP) is designed to engage and recognize providers who improve population health by contributing to quality and appropriate, efficient care. The combined effect improves quality and slows unnecessary growth in the medical cost trend for HHP's attributed members.

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

Both programs are annual programs starting on January 1, 2023, and ending December 31, 2023. 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.

QPP

POINTS POSSIBLE BY SPECIALTY
QUALITY PERFORMANCE PROGRAM

Page	13	14	15	19	22	23	25	27
	Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars (points per webinar)	Participation in HHP Clinical Workgroups (points per workgroup)	Avoidable ED Utilization	Hospital-Acquired Harm	Medication Reconciliation Post Discharge	Sepsis and Septic Shock Management Bundle	Vermont Oxford Network for VLBW and Expanded Database Measures
PRIMARY CARE (carrying a panel)								
Advanced Practice RN (APRN) carrying a primary care panel	0.5	0.125	1	1	1	1		
Family Medicine (PCP)	0.5	0.125	1	1	1	1		
General Practice (PCP)	0.5	0.125	1	1	1	1		
Internal Medicine (PCP)	0.5	0.125	1	1	1	1		
Pediatrics (PCP)	0.5	0.125	1	1	1			
SPECIALIST								
Adolescent Medicine (non-PCP)	0.5	0.125	1	1	1			
Allergy & Immunology	0.5	0.125	1	1	1			
Anesthesiology	0.5	0.125	1		1			
Cardiac Electrophysiology	0.5	0.125	1	1	1			
Cardiology	0.5	0.125	1	1	1			
Cardiothoracic Surgery	0.5	0.125	1	1	1		1	
Child & Adolescent Psychiatry	0.5	0.125	1	1	1			
Clinical Psychology	0.5	0.125	1	1	1			
Critical Care Medicine	0.5	0.125	1		1		2	
Dermatology	0.5	0.125	1	1	1			
Dermatopathology	0.5	0.125	1	1	1			
Developmental-Behavioral Peds	0.5	0.125	1	1	1			
Diagnostic Radiology	0.5	0.125	1		1			
Emergency Medicine	0.5	0.125	1	1	1		2	
Endocrinology	0.5	0.125	1	1	1			
Family Medicine (non-PCP)	0.5	0.125	1	1	1			
Gastroenterology	0.5	0.125	1	1	1			
General Practice (non-PCP)	0.5	0.125	1	1	1			
General Surgery	0.5	0.125	1	1	1		1	
Geriatric Medicine	0.5	0.125	1	1	1			

QPP

POINTS BY SPECIALTY
QUALITY PERFORMANCE PROGRAM

	Page	13	14	15	19	22	23	25	27
		Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars (points per webinar)	Participation in HHP Clinical Workgroups (points per workgroup)	Avoidable ED Utilization	Hospital-Acquired Harm	Medication Reconciliation Post Discharge	Sepsis and Septic Shock Management Bundle	Vermont Oxford Network for VLBW and Expanded Database Measures
Gynecologic Oncology		0.5	0.125	1	1	1		1	
Gynecology		0.5	0.125	1	1	1		1	
Hematology/Oncology		0.5	0.125	1	1	1			
Hospice and Palliative Medicine		0.5	0.125	1	1	1			
Hospitalist - Family Medicine		0.5	0.125	1	1	1		2	
Hospitalist - Internal Medicine		0.5	0.125	1	1	1		2	
Hospitalist - Pediatrics		0.5	0.125	1	1	1			
Infectious Disease		0.5	0.125	1	1	1			
Internal Medicine (non-PCP)		0.5	0.125	1	1	1			
Interventional Cardiology		0.5	0.125	1	1	1			
Interventional Radiology		0.5	0.125	1	1	1			
Maternal & Fetal Medicine		0.5	0.125	1	1	1			
Medical Genetics		0.5	0.125	1		1			
Medical Oncology		0.5	0.125	1	1	1			
Neonatology		0.5	0.125	1		1			2.5
Nephrology		0.5	0.125	1	1	1			
Neurology		0.5	0.125	1	1	1			
Neuroradiology		0.5	0.125	1		1			
Neurosurgery		0.5	0.125	1	1	1		1	
Nuclear Medicine		0.5	0.125	1		1			
Obstetrics & Gynecology		0.5	0.125	1	1	1		1	
Occupational Medicine		0.5	0.125	1	1	1			
Ophthalmology		0.5	0.125	1	1	1		1	
Orthopedic Surgery		0.5	0.125	1	1	1		1	
Otolaryngology		0.5	0.125	1	1	1		1	
Pain Management		0.5	0.125	1	1	1			
Pathology		0.5	0.125	1		1			
Pediatric Cardiology		0.5	0.125	1	1	1			

QPP

POINTS BY SPECIALTY
QUALITY PERFORMANCE PROGRAM

Page	13	14	15	19	22	23	25	27
	Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars (points per webinar)	Participation in HHP Clinical Workgroups (points per workgroup)	Avoidable ED Utilization	Hospital-Acquired Harm	Medication Reconciliation Post Discharge	Sepsis and Septic Shock Management Bundle	Vermont Oxford Network for VLBW and Expanded Database Measures
Pediatric Critical Care	0.5	0.125	1		1			
Pediatric Diagnostic Radiology	0.5	0.125	1		1			
Pediatric Emergency Medicine	0.5	0.125	1	1	1			
Pediatric Endocrinology	0.5	0.125	1	1	1			
Pediatric Gastroenterology	0.5	0.125	1	1	1			
Pediatric Hematology/Oncology	0.5	0.125	1	1	1			
Pediatric Infectious Diseases	0.5	0.125	1	1	1			
Pediatric Nephrology	0.5	0.125	1	1	1			
Pediatric Neurology	0.5	0.125	1	1	1			
Pediatric NICU	0.5	0.125	1		1			2.5
Pediatric Ophthalmology	0.5	0.125	1	1	1		1	
Pediatric Orthopedic Surgery	0.5	0.125	1	1	1		1	
Pediatric Physical Medicine & Rehab	0.5	0.125	1	1	1			
Pediatric Pulmonology	0.5	0.125	1	1	1			
Pediatric Rheumatology	0.5	0.125	1	1	1			
Pediatric Sports Medicine	0.5	0.125	1	1	1			
Pediatric Surgery	0.5	0.125	1	1	1			
Pediatric Urology	0.5	0.125	1	1	1			
Pediatrics (non-PCP)	0.5	0.125	1	1	1			
Physical Medicine & Rehab	0.5	0.125	1	1	1			
Plastic Surgery	0.5	0.125	1	1	1		1	
Podiatry	0.5	0.125	1	1	1		1	
Psychiatry	0.5	0.125	1	1	1			
Pulmonology	0.5	0.125	1	1	1			
Radiation Oncology	0.5	0.125	1	1	1			
Repro Endocrine/Infertility	0.5	0.125	1	1	1			
Rheumatology	0.5	0.125	1	1	1			
Sleep Medicine	0.5	0.125	1	1	1			

QPP

POINTS BY SPECIALTY
QUALITY PERFORMANCE PROGRAM

	Page	13	14	15	19	22	23	25	27
		Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars (points per webinar)	Participation in HHP Clinical Workgroups (points per workgroup)	Avoidable ED Utilization	Hospital-Acquired Harm	Medication Reconciliation Post Discharge	Sepsis and Septic Shock Management Bundle	Vermont Oxford Network for VLBW and Expanded Database Measures
Sports Medicine		0.5	0.125	1	1	1			
Surgical Oncology		0.5	0.125	1	1	1		1	
Thoracic Surgery		0.5	0.125	1	1	1		1	
Urgent Care/Walk-In		0.5	0.125	1	1	1			
Urogynecology & Pelvic Reconstruction		0.5	0.125	1	1	1		1	
Urology		0.5	0.125	1	1	1		1	
Vascular Surgery		0.5	0.125	1	1	1		1	
Weight Management		0.5	0.125	1	1	1			
Wound Care		0.5	0.125	1	1	1			

SSP

POINTS BY SPECIALTY
SHARED SAVINGS PROGRAM

Page	13	14	15	29	31	33	34	36
	Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars points per webinar	Participation in HHP Clinical Workgroups (points per workgroup)	Increasing Ambulatory Surgery (points per Center Use	Mammogram Imaging Callback Rates	Postpartum Care	Specialty to Primary Care Patient Transition	Use of High-Risk Medications in the Elderly
PRIMARY CARE (carrying a panel)								
Advanced Practice RN (APRN) carrying a primary care panel	0.5	0.125	1			1		1
Family Medicine (PCP)	0.5	0.125	1			1		1
General Practice (PCP)	0.5	0.125	1			1		1
Internal Medicine (PCP)	0.5	0.125	1			1		1
Pediatrics (PCP)	0.5	0.125	1			1		
SPECIALIST								
Adolescent Medicine (non-PCP)	0.5	0.125	1				1	1
Allergy & Immunology	0.5	0.125	1				1	1
Anesthesiology	0.5	0.125	1					1
Cardiac Electrophysiology	0.5	0.125	1				1	1
Cardiology	0.5	0.125	1				1	1
Cardiothoracic Surgery	0.5	0.125	1					1
Child & Adolescent Psychiatry	0.5	0.125	1				1	
Clinical Psychology	0.5	0.125	1				1	1
Critical Care Medicine	0.5	0.125	1					1
Dermatology	0.5	0.125	1				1	1
Dermatopathology	0.5	0.125	1				1	
Developmental-Behavioral Peds	0.5	0.125	1				1	
Diagnostic Radiology	0.5	0.125	1		1			
Emergency Medicine	0.5	0.125	1					1
Endocrinology	0.5	0.125	1				1	1
Family Medicine (non-PCP)	0.5	0.125	1				1	1
Gastroenterology	0.5	0.125	1	1			1	1
General Practice (non-PCP)	0.5	0.125	1				1	1
General Surgery	0.5	0.125	1	1				1
Geriatric Medicine	0.5	0.125	1				1	1
Gynecologic Oncology	0.5	0.125	1				1	1
Gynecology	0.5	0.125	1	1		1	1	1
Hematology/Oncology	0.5	0.125	1				1	1
Hospice and Palliative Medicine	0.5	0.125	1					1

SSP

POINTS BY SPECIALTY
SHARED SAVINGS PROGRAM

	Page	13	14	15	29	31	33	34	36
		Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars points per webinar	Participation in HHP Clinical Workgroups (points per workgroup)	Increasing Ambulatory Surgery (points per Center Use	Mammogram Imaging Callback Rates	Postpartum Care	Specialty to Primary Care Patient Transition	Use of High-Risk Medications in the Elderly
Hospitalist - Family Medicine		0.5	0.125	1					1
Hospitalist - Internal Medicine		0.5	0.125	1					1
Hospitalist - Pediatrics		0.5	0.125	1					1
Infectious Disease		0.5	0.125	1				1	1
Internal Medicine (non-PCP)		0.5	0.125	1				1	1
Interventional Cardiology		0.5	0.125	1					1
Interventional Radiology		0.5	0.125	1					
Maternal & Fetal Medicine		0.5	0.125	1					
Medical Genetics		0.5	0.125	1				1	
Medical Oncology		0.5	0.125	1				1	1
Neonatology		0.5	0.125	1					
Nephrology		0.5	0.125	1				1	1
Neurology		0.5	0.125	1				1	1
Neuroradiology		0.5	0.125	1					
Neurosurgery		0.5	0.125	1					1
Nuclear Medicine		0.5	0.125	1					
Obstetrics & Gynecology		0.5	0.125	1	1		1	1	1
Occupational Medicine		0.5	0.125	1					1
Ophthalmology		0.5	0.125	1	1				1
Orthopedic Surgery		0.5	0.125	1	1				1
Otolaryngology		0.5	0.125	1	1				1
Pain Management		0.5	0.125	1				1	
Pathology		0.5	0.125	1					
Pediatric Cardiology		0.5	0.125	1				1	
Pediatric Critical Care		0.5	0.125	1					
Pediatric Diagnostic Radiology		0.5	0.125	1					
Pediatric Emergency Medicine		0.5	0.125	1					
Pediatric Endocrinology		0.5	0.125	1				1	
Pediatric Gastroenterology		0.5	0.125	1				1	
Pediatric Hematology/Oncology		0.5	0.125	1				1	
Pediatric Infectious Diseases		0.5	0.125	1				1	
Pediatric Nephrology		0.5	0.125	1				1	

SSP

POINTS BY SPECIALTY
SHARED SAVINGS PROGRAM

Page	13	14	15	29	31	33	34	36
	Attendance at HHP Annual Membership Meeting	Attendance at HHP Webinars points per webinar	Participation in HHP Clinical Workgroups (points per workgroup)	Increasing Ambulatory Surgery (points per Center Use	Mammogram Imaging Callback Rates	Postpartum Care	Specialty to Primary Care Patient Transition	Use of High-Risk Medications in the Elderly
Pediatric Neurology	0.5	0.125	1				1	
Pediatric NICU	0.5	0.125	1					
Pediatric Ophthalmology	0.5	0.125	1	1				
Pediatric Orthopedic Surgery	0.5	0.125	1	1				
Pediatric Physical Medicine & Rehab	0.5	0.125	1				1	
Pediatric Pulmonology	0.5	0.125	1				1	
Pediatric Rheumatology	0.5	0.125	1				1	
Pediatric Sports Medicine	0.5	0.125	1				1	
Pediatric Surgery	0.5	0.125	1	1				
Pediatric Urology	0.5	0.125	1	1				
Pediatrics (non-PCP)	0.5	0.125	1				1	
Physical Medicine & Rehab	0.5	0.125	1				1	1
Plastic Surgery	0.5	0.125	1	1				1
Podiatry	0.5	0.125	1	1				1
Psychiatry	0.5	0.125	1				1	1
Pulmonology	0.5	0.125	1				1	1
Radiation Oncology	0.5	0.125	1	1				1
Repro Endocrine/Infertility	0.5	0.125	1				1	
Rheumatology	0.5	0.125	1				1	1
Sleep Medicine	0.5	0.125	1				1	1
Sports Medicine	0.5	0.125	1				1	1
Surgical Oncology	0.5	0.125	1					1
Thoracic Surgery	0.5	0.125	1					1
Urgent Care/Walk-In	0.5	0.125	1					1
Urogynecology & Pelvic Reconstruction	0.5	0.125	1	1				1
Urology	0.5	0.125	1	1				1
Vascular Surgery	0.5	0.125	1					1
Weight Management	0.5	0.125	1				1	1
Wound Care	0.5	0.125	1					1

QUALITY PERFORMANCE PROGRAM & SHARED SAVINGS PROGRAM

QUALITY PERFORMANCE PROGRAM

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 collective HPH hospital system quality performance threshold was achieved for the measurement year.

3. The individual HPH hospital performance threshold was achieved for the HPH hospital at which the provider is associated, based on medical staff membership. In the event a provider is a member of the medical staff of more than one HPH hospital, the provider will be asked to designate one hospital where the majority of his or her work is done. Providers may contact HHP to change their primary facility. This designation is reviewed during the credentialing and reappointment process, and is subject to approval by the HHP Board of Managers. Measure eligibility will be based on the provider's primary facility during the majority of the measurement period.

4. 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.

SHARED SAVINGS PROGRAM

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. Cost of care target is achieved, resulting in the funding of the bonus pool for the Shared Savings Program.

3. The provider meets the quality thresholds for applicable measures, based on the provider's specialty or clinical practice area and the minimum patient threshold for measures with defined thresholds.

    a. For PCPs, the Shared Savings payout will be calculated based on the points earned multiplied by either the number of attributed lives at the end of the measurement year or the date of their departure from HHP in the event of separation.

    b. For Specialists, the Shared Savings payout will be calculated based on the points earned multiplied by their specialty tier. Specialty tiers are set according to impact on Medical Cost Trend.

Creating a healthier Hawai'i

MEASURES IN BOTH QUALITY PERFORMANCE AND SHARED SAVINGS PROGRAMS

ENGAGEMENT

ATTENDANCE AT HHP ANNUAL MEMBERSHIP MEETING

Measure Objective	Providers are the cornerstone to making health care payment transformation work. Provider involvement in HHP is critical to its success. This measure encourages provider engagement, provides opportunities for collaboration and networking among HHP members, and shares information about HHP programs, initiatives, and physician-led enterprises.
Description	Attendance at and participation in the HHP Annual Membership Meeting
Points	Total Points: 1 • QPP: 0.5 point • SSP: 0.5 point
Program	QPP & SSP
Exclusion	N/A
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	Points will be awarded upon attendance of the meeting or completion of post-meeting viewing requirements. A video recording of the annual meeting will be made available at a future date for those providers who were absent due to unavoidable clinical duties. Access to the video and requirements for post-meeting viewing credit will be sent to those who provide prior notification.
Eligible Members	All eligible HHP Members

ENGAGEMENT

ATTENDANCE AT HHP WEBINARS

Measure Objective	Providers are the cornerstone to making health care payment transformation work. Your involvement in HHP is critical to its success. This measure encourages and provides opportunities for information sharing and engagement with HHP members.
Description	Attendance and participation at the HHP Webinars
Points	Maximum 1 Point - attend up to 4 webinars • 0.25 point per webinar o 0.125 point QPP o 0.125 point SSP Presenters at HHP Webinars are eligible to earn 1 point (0.5 point QPP & 0.5 point SSP) if they attest to at least 3-hours of work in preparation for the presentation or if continuing medical education credit was offered.
Program	QPP & SSP
Exclusion	N/A
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	4 webinars attended (attended live OR viewed recording and correctly answered questions within 2 weeks of live webinar)
Eligible Members	All eligible HHP members
How to Meet the Measure	Providers must register via the pre-survey form and attend at least 4 live webinars during the measurement year. Credit may be given if providers view the recording and correctly answer post-video questions ***within 2 weeks of the live webinar.***

CITIZENSHIP

PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

Measure Objective

Value-based care introduces new concepts that are often difficult to incorporate into our traditional healthcare workflows including population health, quality, care coordination, and cost of care. This measure aims to increase multi-specialty 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 a 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 a HHP Committee.

See hawaiihealthpartners.org for more information on available workgroups and related responsibilities.

Points

Total possible points per workgroup: 1 - 4 points

Workgroup Member

- Meaningful participation and attendance of at least 50% of meetings held earns **0.5 QPP point** and **0.5 SSP point** (a total of 1 point).
- Meaningful participation and attendance of at least 75% of meetings held earns **1 QPP point** and **1 SSP point** (a total of 2 points).

Workgroup Chair

- Chairing a workgroup earns **2 QPP points** and **2 SSP points** (a total of 4 points).

HHP Committee Chair

- Chairing a committee earns **2 QPP points** and **2 SSP points** (a total of 4 points).

Program

QPP & SSP

Inclusion

All eligible HHP members

Exclusion

N/A

Measurement Period

January 1, 2023 - December 31, 2023

Performance Target

Active participation in workgroups as reflected by attendance of at least 50% and demonstration of meaningful participation of workgroup member

Eligible Members

All eligible HHP members

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PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

How to Meet the Measure

Points earned will be determined by meaningful participation and contribution through attendance of at least 50% of meetings and through the demonstration of actual and verifiable work performed by workgroup members. Actual, verifiable work is defined as completing a workgroup task appropriate to the skills, education and/or training of a 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 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.**

Workgroup Chair Job Description

Each workgroup chair is eligible to receive up to four points: two QPP points and two SSP points.

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.

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PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

Committee Chair Job Description

Each committee chair is eligible to receive up to four points: two QPP points two SSP points.

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.
8. Maintain an environment that welcomes all points of view, with a willingness to thoroughly discuss contentious or complex issues.

Creating a healthier Hawai'i

QUALITY PERFORMANCE PROGRAM MEASURES

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. This measure aims to direct patients to seek initial care in the most appropriate care setting.
Description	Percentage of ED visits by HMSA Commercial attributed patients that are "avoidable" according to adapted NYU criteria
Points	1
Program	QPP
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, 2023 - December 31, 2023
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: Specialties engaging in face-to-face patient care Excludes Anesthesiology, Critical Care Medicine, Diagnostic Radiology, Medical Genetics, Neonatology, Neuroradiology, Nuclear Medicine, Pathology, Pediatric Critical Care, Pediatric Diagnostic Radiology, and Pediatrics - NICU

[1]From https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html. Retrieved on 11/1/2022

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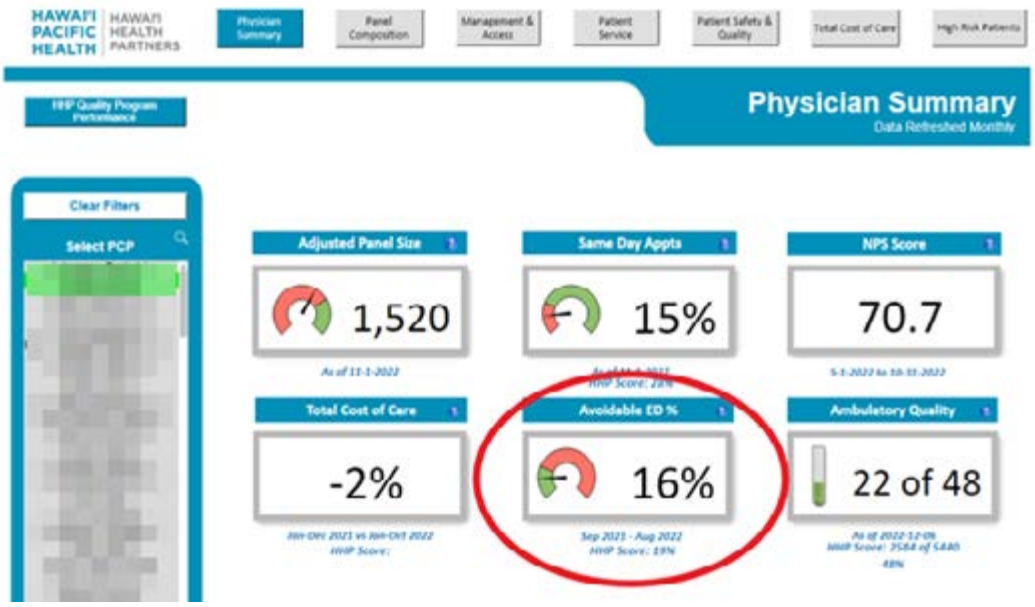
AVOIDABLE ED UTILIZATION

How to *monitor* the measure

Primary Care: Monitor your panel's avoidable ED visits on the HHP Primary Care Dashboard in Epic (see below).

Specialists: Monitor the overall HHP avoidable ED performance on your scorecard on the HHP Specialist Dashboard in Epic.

Hawai'i Health Partners PCP Dashboard



Each ED visit is considered "avoidable" as determined by the likelihood that an individual ED visit was "avoidable" according to NYU's 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 according to the adapted NYU Avoidable ED algorithm 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).

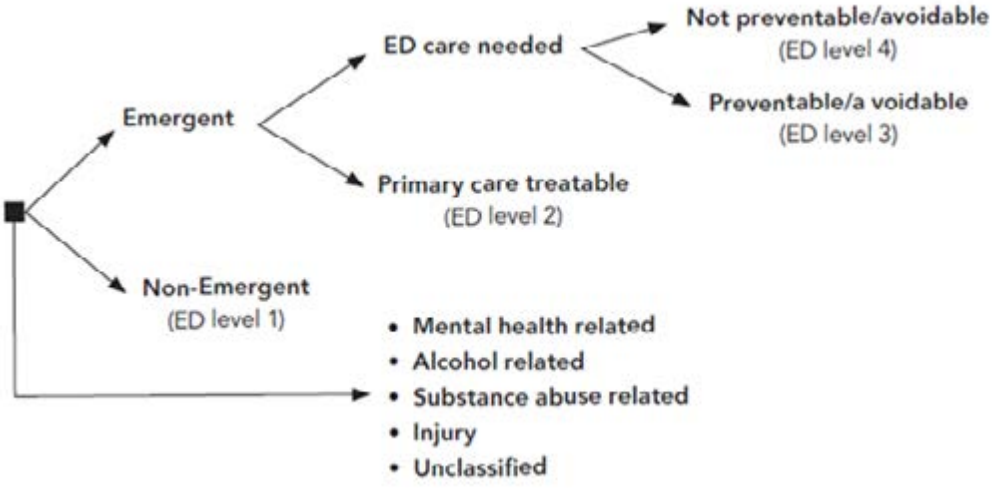
continued on next page

AVOIDABLE ED UTILIZATION

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



CARE DELIVERY

HOSPITAL ACQUIRED HARM

Measure Objective	The Office Inspector General wrote a brief reporting that 25% of Medicare patients experienced harm during hospitals stays occurring in a 1 month period, resulting in over $300 million in additional costs. Approximately 43% of events were preventable. [2]This measure aims to engage hospital-based physicians in efforts to eliminate six types of hospital acquired harm: Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), Clostridium difficile, MRSA infection, hospital associated injury, hospital acquired stage 3 or 4 pressure ulcers, thereby improving safety and eliminating waste 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.
Points	• 0.5 point: ≤6 events / 10,000 patient days **in aggregate by facility** • 1 Point: ≤2 events / 10,000 patient days **in aggregate by facility**
Program	QPP
Numerator	Total number of harm incidents
Denominator	Number of patient days
Exclusions	N/A
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	≤2 events / 10,000 patient days in **aggregate by facility**
Minimum Case Threshold	5 hospital encounters (inpatient or ED)
Eligible Members	All members with hospital activity

[2]U.S. Department of Health and Human Services Office of Inspector General. "Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018." May 2022, OEI-06-18-00400

MEDICATION RECONCILIATION POST-DISCHARGE

Measure Objective	Medication errors result in 7000 to 9000 deaths and over $40 billion in spending annually in the US[3]. Over 40% of medication errors occur during transitions of care[4]. This measure aims to reduce medication errors such as omissions, duplications, dosing errors, or drug interactions by reconciling medications post discharge.
Description	Percentage of discharges from January 1 – December 1 of the measurement year for patients age 65 years or older for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total)
Points	1
Program	QPP
Numerator	Patients from denominator for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total)
Denominator	Patients age 65 years or older discharged from January 1 - December 1, 2023
Exclusions	Patients in hospice anytime during the measurement year Patients who remain in an acute or non-acute facility through December 1 of the measurement year
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	Primary Care: **Overall HHP aggregate score** at or above 50%
Eligible Members	Primary Care: Internal Medicine, General Practice, Family Medicine, and APRNs carrying a primary care panel of attributed lives patients at the end of the measurement period

[3]From https://www.ncbi.nlm.nih.gov/books/NBK519065/. Reviewed on 11/1/2022.
[4]Rozich JD, Howard RJ, Justeson JM, Macken PD, Lindsay ME, Resar RK. Standardization as a mechanism to improve safety in health care. Jt Comm J Qual Saf. 2004 Jan;30(1):5-14. doi: 10.1016/s1549-3741(04)30001-8. PMID: 14738031.

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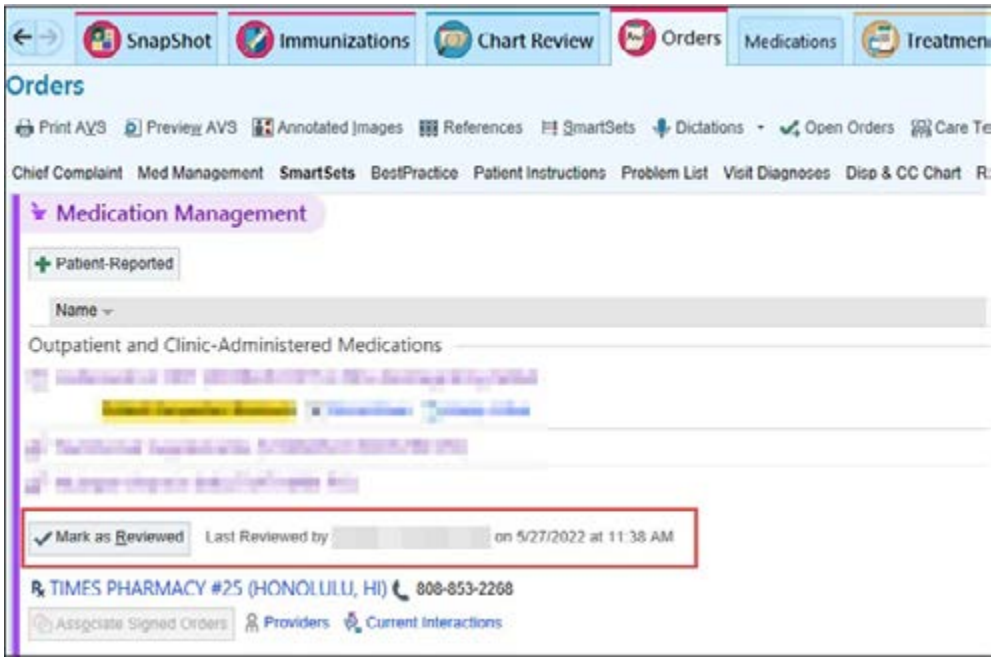
MEDICATION RECONCILIATION POST DISCHARGE

How to Meet the Measure

Complete medication reconciliation within 30 days of discharge. Check the "Mark as Reviewed" button in the Medication Review section.



If you do not use Epic as your primary electronic medical record, please reach out to us at info@HawaiiHealthPartners.org to work with you on an alternative method to provide you with QPP/SSP credit for the measure.

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 is associated with decreased mortality and improved patient outcomes. This measure aims 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).

Points

Critical Care Medicine, Emergency Medicine, Hospitalist - Family Medicine, Hospitalist - Internal Medicine, eligible to earn:

- ≥70% = 1 point
- ≥80% = 2 points

Applicable surgeons eligible to earn:

- ≥70% = 0.5 point
- ≥80% = 1 point

Program

QPP

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)
F. In the event of persistent hypotension after initial fluid administration (MAP <65 mmHg) 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

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SEPSIS AND SEPTIC SHOCK: MANAGEMENT BUNDLE (COMPOSITE MEASURE)

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).

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, 2023 - December 31, 2023

Performance Target

To be scored in **aggregate by facility**
≥80%

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, and applicable surgeons:

- Cardiothoracic Surgery
- General Surgery
- Gynecologic Oncology
- Gynecology
- Neurosurgery
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Plastic Surgery
- Podiatry
- Surgical Oncology
- Thoracic Surgery
- Urogynecology/Pelvic Reconstruction
- Urology
- Vascular Surgery

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[5]." 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 Vermont Oxford Network (VON) measures for very low birth weight (VLBW) and expanded database patients • VLBW - Incidence of necrotizing enterocolitis • VLBW - Nosocomial infection • VLBW - Any human milk at discharge to home • VLBW - Death or Morbidity • VLBW - Oxygen at 36 weeks • Expanded - Nosocomial infection • Expanded - Any human milk as discharge to home • Expanded - Mortality Excluding Early Deaths
Points	Maximum 2.5 (8 measures x 0.3125 points/measure)
Program	QPP
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 = 0.3125 points for each measure x 8
Eligible Members	Neonatologists and Pediatricians practicing as NICU Hospitalists who are members of the Pacific Health Medical Group Division of Neonatology

[5]From https://public.vtoxford.org/who-we-are-overview/. Retrieved 11/1/2022.

SHARED SAVINGS PROGRAM MEASURES

INCREASING AMBULATORY SURGERY CENTER USE

Measure Objective	Shifting procedures from hospital settings to ambulatory surgical centers lowers the cost of care while increasing patient convenience and satisfaction and improving access. This measure aims to promote movement of appropriate cases into an ambulatory surgery center.
Description	Increase the number of surgical cases completed in an ambulatory surgery center
Points	1
Program	SSP
Numerator	Total number of cases performed in an ambulatory surgery center
Denominator	N/A
Exclusions	N/A
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	Total case targets scored by specialty group • Gastroenterology: 1360 • Ophthalmology: 440 • Orthopedic Surgery: 1390 • Otolaryngology: 375 • Pediatric Urology: 135 • Urology: 180 • General Surgery: 30 • Gynecology/Obstetrics & Gynecology/Urogynecology & Pelvic Reconstruction: 30 • Pediatric Ophthalmology: 30 • Pediatric Orthopedic Surgery: 30 • Pediatric Surgery: 30 • Plastic Surgery: 30 • Podiatry: 30 • Radiation Oncology: 30
Minimum Case Threshold	N/A

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INCREASING AMBULATORY SURGERY CENTER USE

Eligible Members

- Gastroenterology
- General Surgery
- Gynecology/Obstetrics & Gynecology/Urogynecology & Pelvic Reconstruction
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pediatric Ophthalmology
- Pediatric Orthopedic Surgery
- Pediatric Surgery
- Pediatric Urology
- Plastic Surgery
- Podiatry
- Radiation Oncology
- Urology

How to Meet the Measure

Complete the target number of cases as a specialty group in an ambulatory surgery center.

MAMMOGRAM IMAGING CALLBACK RATES

Measure Objectives

High-quality screening mammography has been shown to substantially reduce mortality from breast cancer. The mammogram imaging callback rate is a performance measure because it directly relates to the rate of false-positive examinations[6]. This measure aims to reduce variation in mammogram imaging callback rates thereby balancing the need to detect breast cancer while avoiding stressful and costly additional images.

How to Meet the Measure

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*

Points	1
Program	SSP
Numerator	Number of mammograms identified as needing additional imaging evaluation
Denominator	Total number of mammograms performed
Exclusions	N/A
Measurement Period	January 1, 2023 - December 31, 2023

[6]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.

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MAMMOGRAM IMAGING CALLBACK RATES

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

POSTPARTUM CARE

Measure Objective	The postpartum period is a critical time for a woman and her infant, setting the stage for long-term health and well-being[7]. This measure aims to improve the rate of postpartum visits in order to improve maternal and perinatal health outcomes.
Description	Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery
Points	1
Program	SSP
Numerator	Patients from the denominator with a postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery
Denominator	Number of HMSA Commercial and Quest attributed patients who delivered live births on or between November 6 of the year before the measurement year and November 5 of the measurement year
Exclusions	Patients whose OB/GYN is not an HHP member
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	Primary Care & Specialists: **Overall HHP aggregate score** at or above 50%
Minimum Case Threshold	Primary Care: 5 or more patients who fall into the denominator Specialists: 5 or more patients who fall into the denominator
Eligible Members	Primary Care: Family Medicine, General Practice, Internal Medicine, Pediatrics, and APRNs carrying a primary care panel of attributed lives with 5 or more patients who fall into the denominator Specialists: Obstetrics & Gynecology, Gynecology
How to Meet the Measure	When completing a claim for the routine follow up visit following delivery, please: • Complete Block 14 of the CMS 1500 claim form. This block should show the date of the patient's last menstrual period (LMP). • Bill an appropriate level of new patient or established patient office visit. • Indicate a diagnosis of ICD-10-CM: Z39.1 (Encounter for routine postpartum follow-up) or Z39.2 (Encounter for care and examination for lactating mother) as applicable. For more information on codes for maternity services, please refer to https://hmsa.com/portal/provider/zav_pel.ph.pre.650.htm Accessed: 12/2022

[7]ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. 2018 May;131(5):e140-e150. doi: 10.1097/AOG.0000000000002633. PMID: 29683911.

CARE COORDINATION

SPECIALTY TO PRIMARY CARE PATIENT TRANSITION

Measure Objective

The Annual Report from the Hawaii Physician Workforce Assessment Project shows a statewide shortage of about 732 physician FTEs and 569 specialty FTEs[8]. This measure aims to improve specialty clinic access through the transition of patient care from specialists to primary care providers once the relevant condition is stabilized.

Description

- Identify patients whose referring medical condition has stabilized
- Communicate with the patient that care for the condition will be managed by the patient's primary care provider
- Communicate with the patient's primary care provider that care for the condition is being transitioned to the primary care provider and that specialty provider is available for re-consultation if needed in the future

Points

1

Program

SSP

Numerator

Number of patients whose care was transitioned back to the primary care provider from the specialty provider

Denominator

N/A

Exclusion

N/A

Measurement period

January 1, 2023 - December 31, 2023

Performance Target

10 cases

Minimum Case Threshold

N/A

Eligible Members

- Adolescent Medicine (non-PCP)
- Allergy & Immunology
- Cardiac Electrophysiology
- Cardiology
- Child & Adolescent Psychiatry
- Clinical Psychology
- Dermatology
- Dermatopathology
- Developmental-Behavioral Peds
- Endocrinology
- Family Medicine (non-PCP)
- Gastroenterology
- General Practice (non-PCP)
- Geriatric Medicine
- Gynecologic Oncology
- Gynecology
- Hematology/Oncology
- Infectious Disease
- Internal Medicine (non-PCP)
- Medical Genetics
- Medical Oncology
- Nephrology
- Neurology
- Obstetrics & Gynecology
- Pain Management
- Pediatric Cardiology

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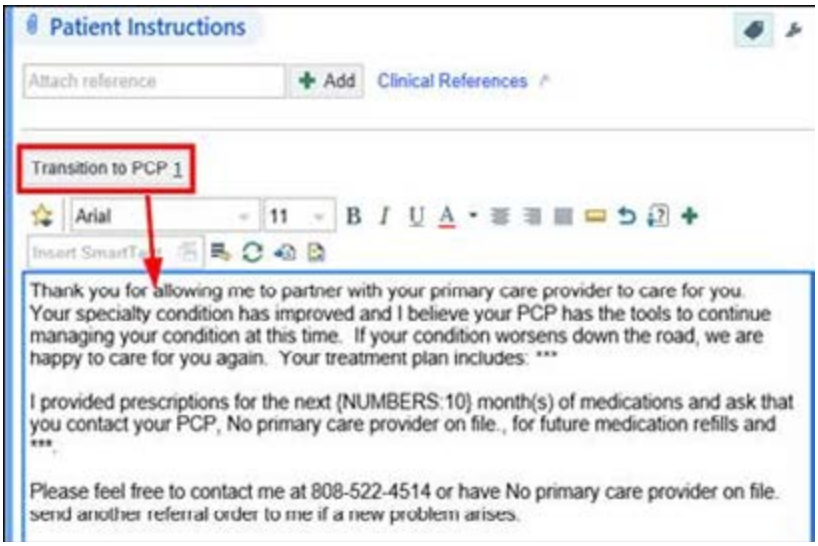
[8]Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project. Act 18, SSLH 2009 (Section 5). Act 186, SLH 2012. Act 40, SLH 2017. December 2022

SPECIALTY TO PRIMARY CARE PATIENT TRANSITION

- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Hematology/Oncology
- Pediatric Infectious Diseases
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Physical Medicine & Rehab
- Pediatric Pulmonology
- Pediatric Rheumatology
- Pediatric Sports Medicine
- Pediatrics (non-PCP)
- Physical Medicine & Rehab
- Psychiatry
- Pulmonology
- Repro Endocrine/Infertility
- Rheumatology
- Sleep Medicine
- Sports Medicine
- Weight Management

How to Meet the Measure

Use the SpeedButtons (see screenshots below) in Epic to document the conversation in the After Visit Summary (AVS) that will be distributed to the patient. Route the AVS to the patient's primary care provider.



If you do not use Epic as your primary electronic medical record, please reach out to us at info@HawaiiHealthPartners.org to work with you on an alternative method to provide you with QPP/SSP credit for the measure.

CARE DELIVERY

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

Measure Objective	The use of high-risk medications in the elderly contributes to increased hospitalizations, length of hospital stays, and duration of illness as well as nursing home placements, falls, and fractures that are further associated with decline in the elderly[9]. This measure aims to reduce adverse outcomes by avoiding high-risk medications for patients 65 years of age and older
Description	Avoid ordering high-risk medications for patients 65 years of age and older (e.g., anticholinergics barbiturates, long-acting sulfonylureas, etc.) whose route is oral, transdermal, or rectal. The measure is intended to alert providers of patients who are 65 years of age and older to consider alternative medication options when medically appropriate. Clinical judgement takes precedent.
Points	1
Program	SSP
Numerator	Patients who were ordered at least one high-risk medication during the measurement period
Measurement Period	January 1, 2023 - December 31, 2023
Performance Target	Provider will earn credit in one of two ways: • ≤20 applicable high risk medication orders in 2023 or • 50% reduction in applicable high risk medication orders compared to 2022 Providers may request reconsideration for cases in which high-risk medication orders for patients in this age group were deemed clinically appropriate by the provider at the time of ordering.
Minimum Case Threshold	100 Epic encounters with a patient 65 years of age or older
Eligible Members	All ordering physicians (includes all specialties other than those excluded below) and APRNs carrying a primary care panel of attributed lives Excludes Dermatopathology, Diagnostic Radiology, Interventional Radiology Maternal & Fetal Medicine, Medical Genetics, Neuroradiology, Nuclear Medicine, Pain Management, Pathology, Repro Endrocin/Infertility, Pediatrics (PCP), Pediatrics (non-PCP), and all pediatric subspecialties.

[9]From https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_238_MIPSCQM.pdf. Retrieved 11/1/2022medication in an elderly patient.

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USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

How to Meet the Measure

Engage with the Epic Best Practice Alert tool notifying provider of a potential high-risk medication in an elderly patient.

HHP will notify providers of their 2022 performance via info@hawaiihealthpartners.org. For more information, contact HHP at info@hawaiihealthpartners.org.

If you do not use Epic as your primary electronic medical record, please reach out to us at info@HawaiiHealthPartners.org to work with you on an alternative method to provide you with QPP/SSP credit for the measure.

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HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

CREATING A HEALTHIER HAWAIʻI