2025

PROGRAM GUIDE

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

CREATING A HEALTHIER HAWAIʻI

CONTENTS

LETTER TO COLLEAGUES:

Thank you for being a valued member of Hawai'i Health Partners (HHP). As we step into 2025, HHP remains steadfast in our commitment to supporting you and fostering resilience in the face of an ever-changing health care landscape. Together, we continue our journey toward creating a healthier community.

In 2025, we are excited to streamline processes to enhance this resilience. One significant change is the evolution of our Quality Performance and Shared Savings Programs (QPP/SSP) into the new HHP Quality Incentive Program (HQIP). Since HHP's inception, these programs have played a pivotal role in educating and incentivizing our physicians and providers to align with our mission and initiatives. As more payers shift to rewarding quality and value, we recognize the growing complexity of program requirements. The HQIP framework introduces a more unified approach, allowing us to better align and support your efforts while partnering with more payers to achieve shared goals.

Resilience also stems from stability. At HHP, we are committed to creating a stable foundation by prioritizing physician and provider engagement, gathering your feedback, and ensuring clarity in our initiatives. In 2025, we will maintain the same program measures with only one addition: an annual meeting. This consistency underscores our dedication to the sustainability and success of our programs and initiatives.

We are also excited to welcome new physicians and providers in our network. In 2025, primary care physicians and mid-level providers from Hawai'i Filipino Healthcare (HFH) and Hawai'i Independent Physicians Association (HIPA) will join HHP. This growth strengthens our resilience and amplifies our collective impact on the health of our community through the patients we care for, the programs we develop, and the services we provide.

The 2025 Quality Incentive Program reflects our commitment to building a healthier community. As always, we are dedicated to listening to your needs, supporting you through our services, and advocating for your success. Thank you for your leadership and partnership in transforming health care in Hawai'i.

Sincerely,
Jennifer Lo, MD
Medical Director

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 physicians and providers, facilities, and hospitals aligned to provide patient-centered, high-quality care. The ACO's goals are to create healthier communities in Hawai'i by focusing on high-quality care, increasing efficiency, and developing a network that provides coordinated care with optimal patient health outcomes.

To engage individual physicians and providers under these goals, Hawai'i Health Partners has a performance program, the HHP Quality Incentive Program (HQIP).

Hawai'i Health Partners Quality Incentive Program

The Hawaii Health Partners Quality Incentive Program (HQIP) is designed to engage and recognize physicians and providers who 1) contribute to achieving quality performance goals in the inpatient setting and 2) improve population health by contributing to quality and appropriate, efficient care.

Eligibility Criteria

A physician or provider is eligible to receive incentives under this program if both criteria have been met:

1. The physician or provider is a credentialed, participating provider of HHP for at least 90 days of the measurement year.
2. The physician or provider meets the quality thresholds for those applicable measures, based on the physician's or provider's specialty or clinical practice area and the minimum patient threshold for measures with defined thresholds.

Performance Target

Performance Target for each measure is based off individual performance, primary facility, or by Clinical Practice Area (CPA). CPA is determined at time of HHP credentialing as the specialty in which you are practicing.

- Example: Specialty = Hospital Medicine and CPA = Hospitalist – IM

Individual vs.. Group Member Participation

Individual performance and incentives will be calculated for all eligible HHP physicians and providers, whether they join as an individual or as a member of the group. For physicians or 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 physicians and providers.

Measurement Period

The quality incentive program starts on January 1, 2025, and ends December 31, 2025. 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.

PARTICIPATION IN ECOSYSTEM, PERFORMANCE, AND BONUS MEASURES BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	ECO-SYSTEM	PERFORMANCE MEASURES										BONUS MEASURES	
	Ecosystem Development	Annual Assessment of Chronic Conditions	Avoidable ED Utilization	HHP Network Engagement – Annual Membership Meeting	HHP Network Engagement – Webinars	Hospital-Acquired Harm	Increasing Ambulatory Surgery Center Use	Mammogram Imaging Callback Rate	Sepsis and Septic Shock Management Bundle	Turnaround Time	Vermont Oxford Network for VLBW and Expanded Database Measures	HHP Network Engagement Presenter	Participation in HHP Clinical Workgroups and Committee Leadership
PRIMARY CARE (carrying a primary care panel of patients)													
Advanced Practice Registered Nurse (APRN)/ Physician Assistant (PA)	✔		✔	✔	✔	✔						✔	✔
Family Medicine (PCP)	✔		✔	✔	✔	✔						✔	✔
General Practice (PCP)	✔		✔	✔	✔	✔						✔	✔
Internal Medicine (PCP)	✔		✔	✔	✔	✔						✔	✔
Pediatrics (PCP)	✔		✔	✔	✔	✔						✔	✔
SPECIALIST													
Adolescent Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Allergy & Immunology	✔	✔	✔	✔	✔	✔						✔	✔
Anesthesiology	✔	✔		✔	✔	✔						✔	✔
Cardiac Electrophysiology	✔	✔	✔	✔	✔	✔						✔	✔
Cardiology	✔	✔	✔	✔	✔	✔						✔	✔
Cardiothoracic Surgery	✔	✔	✔	✔	✔	✔						✔	✔
Child & Adolescent Psychiatry	✔	✔	✔	✔	✔	✔						✔	✔
Clinical Psychology	✔	✔	✔	✔	✔	✔						✔	✔
Critical Care Medicine	✔	✔		✔	✔	✔			✔			✔	✔
Dermatology	✔	✔	✔	✔	✔	✔						✔	✔
Dermatopathology	✔	✔		✔	✔	✔				✔		✔	✔
Developmental-Behavioral Peds	✔	✔	✔	✔	✔	✔						✔	✔
Diagnostic Radiology	✔	✔		✔	✔	✔		✔		✔		✔	✔
Emergency Medicine	✔	✔	✔	✔	✔	✔			✔			✔	✔
Endocrinology	✔	✔	✔	✔	✔	✔						✔	✔

PARTICIPATION IN ECOSYSTEM, PERFORMANCE, AND BONUS MEASURES BY CLINICAL PRACTICE AREA

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Gastroenterology	✔	✔	✔	✔	✔	✔	✔					✔	✔
General Surgery	✔	✔	✔	✔	✔	✔	✔					✔	✔
Geriatric Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Gynecologic Oncology	✔	✔	✔	✔	✔	✔						✔	✔
Gynecology	✔	✔	✔	✔	✔	✔	✔					✔	✔
Hematology/Oncology	✔	✔	✔	✔	✔	✔						✔	✔
Hospice & Palliative Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Hospitalist – Family Medicine	✔	✔	✔	✔	✔	✔			✔			✔	✔
Hospitalist – Internal Medicine	✔	✔	✔	✔	✔	✔			✔			✔	✔
Hospitalist – Pediatrics	✔	✔	✔	✔	✔	✔						✔	✔
Infectious Disease	✔	✔	✔	✔	✔	✔						✔	✔
Interventional Cardiology	✔	✔	✔	✔	✔	✔						✔	✔
Interventional Radiology	✔	✔	✔	✔	✔	✔				✔		✔	✔
Maternal & Fetal Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Medical Genetics	✔	✔		✔	✔	✔						✔	✔
Neonatology	✔	✔		✔	✔	✔					✔	✔	✔
Nephrology	✔	✔	✔	✔	✔	✔						✔	✔
Neurology	✔	✔	✔	✔	✔	✔						✔	✔
Neuroradiology	✔	✔		✔	✔	✔				✔		✔	✔
Neurosurgery	✔	✔	✔	✔	✔	✔						✔	✔
Nuclear Medicine	✔	✔		✔	✔	✔				✔		✔	✔
Obstetrics & Gynecology	✔	✔	✔	✔	✔	✔	✔					✔	✔

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Occupational Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Ophthalmology	✔	✔	✔	✔	✔	✔	✔					✔	✔
Orthopedic Surgery	✔	✔	✔	✔	✔	✔	✔					✔	✔
Otolaryngology	✔	✔	✔	✔	✔	✔	✔					✔	✔
Pain Management	✔	✔	✔	✔	✔	✔						✔	✔
Pathology	✔	✔		✔	✔	✔				✔		✔	✔
Pediatric Anesthesiology	✔	✔		✔	✔	✔						✔	✔
Pediatric Cardiology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Critical Care	✔	✔		✔	✔	✔						✔	✔
Pediatric Diagnostic Radiology	✔	✔		✔	✔	✔				✔		✔	✔
Pediatric Emergency Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Endocrinology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Gastroenterology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Hematology/ Oncology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Infectious Disease	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Nephrology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Neurology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric – NICU	✔	✔		✔	✔	✔					✔	✔	✔
Pediatric Ophthalmology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Orthopedic Surgery	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Physical Medicine & Rehab	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Pulmonology	✔	✔	✔	✔	✔	✔						✔	✔

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Pediatric Rheumatology	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Sports Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Surgery	✔	✔	✔	✔	✔	✔						✔	✔
Pediatric Urology	✔	✔	✔	✔	✔	✔	✔					✔	✔
Pediatrics (non-PCP)	✔	✔	✔	✔	✔	✔						✔	✔
Plastic Surgery	✔	✔	✔	✔	✔	✔	✔					✔	✔
Podiatry	✔	✔	✔	✔	✔	✔	✔					✔	✔
Post-Acute Long-Term Care	✔	✔	✔	✔	✔	✔						✔	✔
Psychiatry	✔	✔	✔	✔	✔	✔						✔	✔
Pulmonology	✔	✔	✔	✔	✔	✔						✔	✔
Radiation Oncology	✔	✔	✔	✔	✔	✔						✔	✔
Reproductive Endocrinology/ Infertility	✔	✔	✔	✔	✔	✔						✔	✔
Rheumatology	✔	✔	✔	✔	✔	✔						✔	✔
Sleep Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Sports Medicine	✔	✔	✔	✔	✔	✔						✔	✔
Urgent Care/Walk-In	✔	✔	✔	✔	✔	✔						✔	✔
Urogynecology & Pelvic Reconstruction	✔	✔	✔	✔	✔	✔						✔	✔
Urology	✔	✔	✔	✔	✔	✔	✔					✔	✔
Vascular Surgery	✔	✔	✔	✔	✔	✔						✔	✔
Weight Management	✔	✔	✔	✔	✔	✔						✔	✔
Wound Care	✔	✔	✔	✔	✔	✔						✔	✔

ECOSYSTEM DEVELOPMENT MEASURE

ECOSYSTEM DEVELOPMENT MEASURE

Measure Objective

Due to the importance of this measure, the threshold set by CPA must be achieved and maintained throughout the year in order to earn credit for all subsequent measures. An accountable care organization (ACO) is defined as a group of physicians and providers that accept collective accountability for the management of quality and cost of care delivered to the patients they serve. ACO physicians and providers work together, coordinating to provide quality, integrated care. Patients benefit when their physicians are committed to team-based care and accept their role in reducing health care costs. The Ecosystem is foundational to the success of Hawai'i Health Partners (HHP) as an ACO. This measure strives to create a strong ecosystem where our patients receive care managed by our physicians and providers. Within our HHP ecosystem, we have the opportunity to:

- Improve communication and coordination of care.
- Increase understanding of network strengths and opportunities for improvement.
- Support maintenance and monitoring of quality.
- Allow ability to innovate within our network.
- Support efforts and initiatives promoting healthy communities.

Description

Percentage of care for HHP patients delivered by HHP physicians and providers in network clinics and facilities.

Numerator

Primary Care: All In-Network HMSA Commercial Claims

Specialists: All In-Network HMSA Commercial Claims

Denominator

Primary Care: All HMSA Commercial claims for the PCPs' attributed patients with a service date in 2025, minus exclusions on next page.

Specialists: All HMSA Commercial claims billed by the HHP Specialist and by facility where service was delivered minus exclusions on next page. If HHP Specialist referred to clinician and referral is documented in claim, then claim will be included as well as other specialists to whom HHP Specialist refers, minus exclusions on next page.

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Exclusion

Out-of-network claims in the areas of care delivery listed below will be excluded from measurement calculation. Exclusions are based on the following criteria:

1. Area of care delivery has no in-network options.
2. Care delivery options exist in-network, but opportunities for enhancing quality and/or cost are limited.

- Addiction Medicine
- All Other Suppliers
- Ambulance
- Anesthesiology
- Audiologist
- Certified Registered Nurse Anesthetist
- Clinical Laboratory
- Clinical Psychologist
- Dentist
- Durable Medical Equipment
- Family Planning Clinic
- Genetics
- Home Infusion
- Hospice
- Licensed Clinical Social Worker
- Marriage, Family, Child Counselor
- Occupational Therapist in Private Practice
- Optician
- Orthotics and Prosthetics
- Out of State
- Pathology
- Pharmacy
- Physiotherapist
- Psychiatric Hospital
- Psychiatry
- Psychologist
- Registered Dietitian/Nutrition Professional
- Renal Dialysis Clinic
- Skilled Nursing Facility
- Speech Therapist
- Substance Abuse Facility

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ECOSYSTEM DEVELOPMENT MEASURE

Measurement Period

January 1, 2025 - December 31, 2025

Performance Target

Performance is measured on an individual level. Targets are set on baseline data from July 2023 to June 2024 for each Clinical Practice Area and are reflected on the HHP dashboard.

Please see Appendix for your Clinical Practice Area target.

If you have any questions about your performance target, contact Info@HawaiiHealthPartners.org to arrange a meeting.

Eligible Members

All HHP Credentialed Members

How to Meet the Measure

How to Monitor Performance:
Physicians and providers can monitor performance on the HHP dashboard. If you need help accessing your dashboard, please contact HHP:

- **Primary Care Physicians:** Contact your Health Practice Liaison or email PCP.Dashboard@HawaiiHealthPartners.org
- **Specialists:** Email Info@HawaiiHealthPartners.org

Physicians and providers whose CPA does not have qualifying baseline data:
They can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.

Physicians and providers with less than 10 claims or are new to HHP in 2025:
They can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.

If you have questions regarding referral opportunities, please email:
Info@HawaiiHealthPartners.org

PERFORMANCE PROGRAM MEASURES

ANNUAL ASSESSMENT OF CHRONIC CONDITIONS

Measure Objective

HHP's focus is to provide programs that engage and recognize physicians and providers who deliver high-quality care and improve patient health outcomes. To be successful, HHP physicians and providers need to collaborate as a system to describe the complexity of illnesses that impact our patient population through the use of appropriate ICD-10 codes. These complexities serve as the basis for risk adjustment and the rationale behind addressing Hierarchical Condition Categories on an annual basis.

Consistent use of the EMR Problem List to communicate patient diagnoses and relevant ICD-10 codes will drive systemwide collaboration. Problem List utilization will also reduce administrative burden and more reliably convey the resources needed to support high-quality patient care.

Description

Attend education sessions on how the complexity of chronic diseases can be consistently communicated in daily practice and what specialists can do support annual systemwide efforts to accurately capture and communicate patient care needs.

Exclusion

N/A

Measurement Period

January 1, 2025 - December 31, 2025

Performance Target

Attend both educational sessions and complete associated test questions by deadline.

Partial credit will be given for completing 1 of the 2 educational sessions and test questions.

Minimum Case Threshold

N/A

Eligible Members

All HHP Specialists

How to Meet the Measure

To obtain full credit for the measure, physicians and providers who are credentialed in the HHP network prior to May 31, 2025, must complete:

- 1st educational session and associated test questions completed by June 30, 2025 AND
- 2nd educational session and associated test questions completed by December 31, 2025

Physicians/Providers who are credentialed in the HHP network after May 31, 2025, can attain full credit for this measure if both educational sessions and test questions are completed prior to December 31, 2025.

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 intends 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
Numerator	Patient ED visits from the denominator that are "avoidable" according to adapted NYU criteria
Denominator	HMSA Commercial attributed patients that present to an Emergency Department
Exclusions	N/A
Measurement Period	January 1, 2025 - December 31, 2025
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, APRNs and PAs. By definition, all Primary Care physicians and providers must carry a panel of attributed lives. **Specialists:** All specialties excluding: Anesthesiology, Critical Care Medicine, Dermatopathology, Diagnostic Radiology, Medical Genetics, Neonatology, Neuroradiology, Nuclear Medicine, Pathology, Pediatric Critical Care, Pediatric Diagnostic Radiology, and Pediatrics - NICU
How to *Monitor* the Measure	**Primary Care:** Monitor your panel's avoidable ED visits on the HHP Primary Care Dashboard in Epic (see next page). **Specialists:** Monitor the overall HHP avoidable ED performance on your scorecard on the HHP Specialist Dashboard in Epic.

[1]From https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html Retrieved on 11/15/2024.

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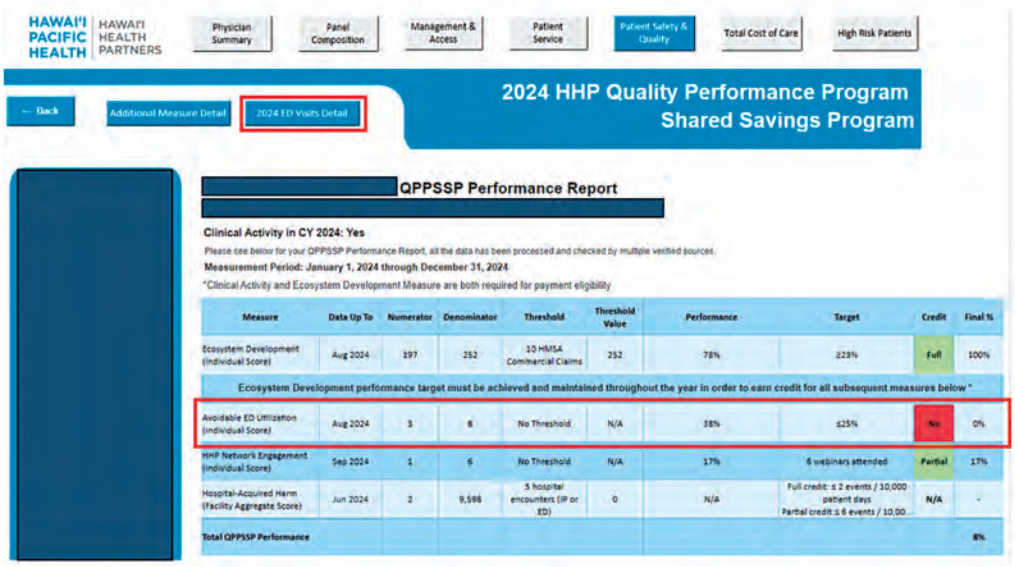
AVOIDABLE ED UTILIZATION

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 attribution 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).

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

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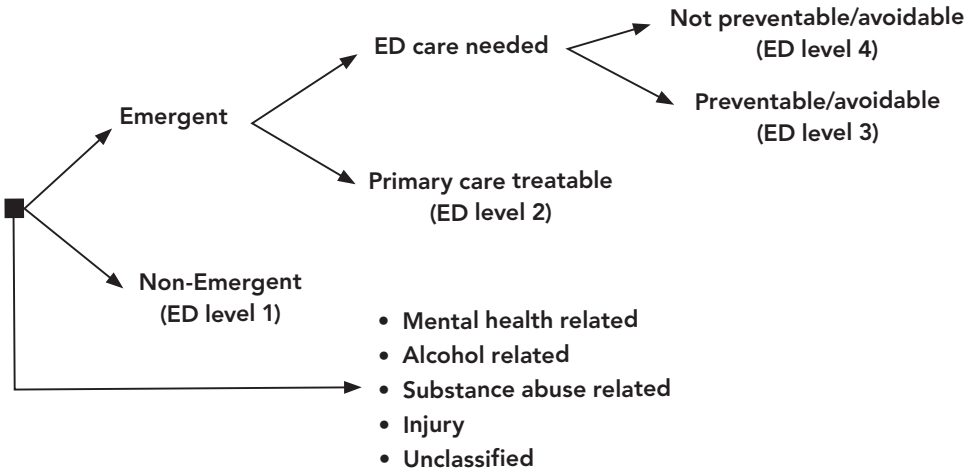
AVOIDABLE ED UTILIZATION



If you have any inquiries regarding member attribution or Avoidable ED criteria, please contact Info@HawaiiHealthPartners.org

NETWORK ENGAGEMENT

HHP NETWORK ENGAGEMENT – ANNUAL MEMBERSHIP MEETING

Measure Objective	Physicians and providers are the cornerstone to patient care. Physician and provider involvement in HHP is critical to its success. This measure encourages physician and provider engagement, presents opportunities for collaboration and networking among HHP members, and shares information about HHP programs, initiatives, and physician-led enterprises.
Description	Attend the HHP Annual Membership Meeting
Exclusions	N/A
Measurement Period	January 1, 2025 - December 31, 2025
Performance Target	Attendance and registration by the designated time. Credit will be awarded upon attendance of the meeting or completion of post-meeting viewing requirements (if exempt due to clinical duties).
Eligible Members	All credentialed HHP Members
How to Meet the Measure	To obtain full credit for the measure, physicians and providers who are credentialed in the HHP network prior to January 1, 2025, must register and attend the HHP Annual membership meeting. An exception will be made for those physicians and providers with late attendance or absence due to unavoidable clinical duties. Prior notification to Info@Hawaiihealthpartners.org is required for late attendance or absence due to unavoidable clinical duties. A video recording and test questions of the annual meeting will be made available at a future date for those physicians and 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. Additionally, these physicians and providers will have 4 weeks to complete the recording and test questions.

NETWORK ENGAGEMENT

HHP NETWORK ENGAGEMENT – WEBINARS

Measure Objective	Physicians and providers are the cornerstone to making health care transformation work. Your involvement and engagement in HHP activity is critical to our success. This measure encourages and provides opportunities for information sharing and engagement with HHP members.
Description	Attendance at the HHP Webinars
Exclusions	N/A
Measurement Period	January 1, 2025 - December 31, 2025
Performance Target	4 webinars attended (attended live OR viewed recording and correctly answered questions within 4 weeks of live webinar). Partial credit will be given for each webinar completed.
Eligible Members	All HHP credentialed members
How to Meet the Measure	**Attend Live Webinar:** Physicians/Providers must register via the pre-survey form and attend up to 4 live webinars during the measurement year. **Recording & Test Questions:** Credit may be given if physicians/providers view the recording and correctly answer post-video questions within 4 weeks of the live webinar posting.

HOSPITAL-ACQUIRED HARM

Measure Objective	Office Inspector General wrote a brief reporting that 25% of Medicare patients experienced harm during hospital stays occurring in a 1-month period, resulting in over $300 million in additional costs. Approximately 43% of events were preventable. This measure intends to engage hospital-based physicians in efforts to eliminate six types of hospital acquired harm: Central Line Associated Blood Stream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Clostridium difficile infections, Methicillin-Resistant Staphylococcus Aureus (MRSA) infections, hospital associated injury, and hospital acquired stage 3 or 4 pressure ulcers, thereby improving safety and reducing health care costs in our in-patient facilities.
Description	Physicians and providers play a crucial role in ensuring patient safety by actively working to prevent hospital-acquired harm. This outcomes-based measure rewards reductions in hospital acquired harm depending on the condition. Strategies to accomplish this include but are not limited to: reduction of central line or urinary catheter utilization, 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. Our responsibility to implement these strategies not only improves patient outcomes but also fosters a culture of accountability and high-quality care in our inpatient facilities.
Numerator	Total number of harm incidents
Denominator	Number of patient days
Measurement Period	January 1, 2025 - December 31, 2025
Performance Target	Full credit: ≤2 events / 10,000 patient days in **aggregate by facility** Partial credit: ≤6 events / 10,000 patient days in **aggregate by facility**
Minimum Case Threshold	5 hospital encounters (inpatient or ED)
Eligible Members	All HHP credentialed members who meet the minimum case threshold of 5 hospital encounters during the measurement period with hospital activity
How to Meet the Measure	• Follow HPH testing and treatment guidelines for C. diff – Adult Treatment Guidelines (page 20) • As an individual physician/provider and in group rounds, regularly assess need for central lines and urinary catheters • Wash hands frequently • Practice antibiotic stewardship

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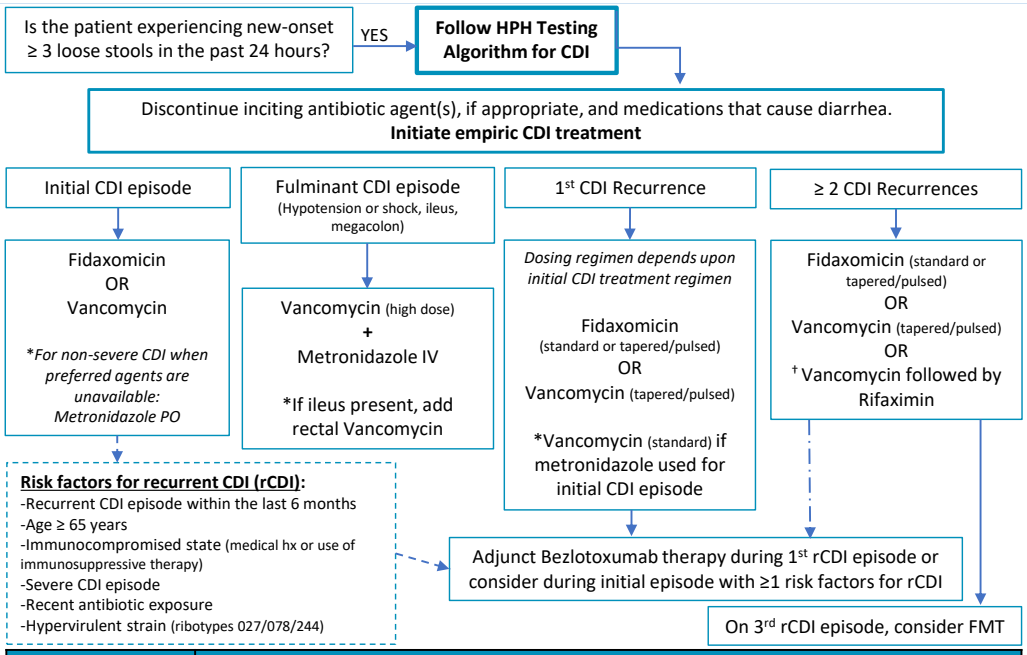
Adult Treatment Guidelines for *Clostridioides difficile* Infection (CDI)



Agent	Regimen/Comments
Fidaxomicin (Dificid)	Standard: 200 mg PO/FT BID x10 days Tapered/Pulsed: 200 mg PO/FT BID x5 days, then 200 mg daily x20 days
Metronidazole (Flagyl)	Standard: 500 mg PO/IV Q8H x10-14 days
Vancomycin	Standard: 125 mg PO/FT QID x10 days Tapered/Pulsed: 125 mg PO/FT QID x10-14 days, then 125 mg BID x7 days, then 125 mg daily for 7 days, then 125 mg Q2-3 days for 2-8 weeks High dose: 500 mg PO/FT Q6H Rectal: 500 mg in NS (for irrigation) 100 mL PR Q6H †Alt option (off-label): standard vancomycin regimen, followed by Rifaximin 400 mg PO TID x20 days
Bezlotoxumab (Zinplava) **ID APPROVAL**	Indication: reduce recurrence of CDI in patients ≥ 1 years of age who are receiving Standard of Care (SOC) antibiotic treatment for CDI and are at high risk for rCDI. Caution: history of congestive heart failure (risk serious HF occurrence, increased morbidity risk). Dose: 10 mg/kg IV once during administration of SOC antibiotics. For billing & reimbursement information: Merck Access Program
Fecal Microbiota Transplant (FMT) **ID APPROVAL** *Assess if outpatient therapy possible.*	Indication: prevention of CDI recurrence in patients ≥ 18 years of age, after SOC antibiotic treatment for rCDI. Rebyota: 150 mL PR once, administered 24-72 hours after last SOC antibiotic dose. For coverage support: www.rebyotahcp.com Vowst: 4 capsules PO daily x3 days, administer 48-96 hours after last SOC antibiotic dose. Requires bowel prep 1 day prior and at least 8 hours prior to 1st Vowst dose. For coverage support: VOWST VOYAGE™ SUPPORT PROGRAM | VOWST Purified Microbiome Therapeutic, Oral-mcdf Additional option: OpenBiome (investigational FMT preparations)

References:
Clinical Practice Guidelines by IDSA and SHEA: 2021 Focused Update Guidelines on Management of Clostridioides difficile Infection in Adults
Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by IDSA and SHEA.
Cornely OA et al. Treatment of First Recurrence of Clostridium difficile Infection: Fidaxomicin Versus Vancomycin. Clin Infect Dis. 2012; 55(Suppl 2):S154-61.
Gerding DN et al. Bezlotoxumab for Prevention of Recurrent Clostridium difficile Infection in Patients at Increased Risk for Recurrence. Clin Infect Dis. 2018; 67(5):649-56.

Revised 9.202

Merck Access Program

www.rebyotahcp.com

VOWST VOYAGE ™ SUPPORT PROGRAM | VOWST Purified Microbiome Therapeutic, Oral mcdf

CARE COORDINATION

INCREASING AMBULATORY SURGERY CENTER USE

Measure Objective	Safely shifting appropriate procedures from hospital settings to ambulatory surgical centers, saves millions of dollars annually while increasing patient convenience and satisfaction and improving access. This measure intends to promote movement of appropriate cases into an ambulatory surgery center.
Description	Increase the rate of appropriate surgical cases completed in an ambulatory surgery center
Numerator	Total number of cases performed in an ambulatory surgery center
Denominator	Total number of cases performed in an ambulatory surgery center and/or hospital-based facility
Exclusion	Surgical cases performed on patients determined to be ASA Class III or higher as defined by the American Society of Anesthesiology Physical Status Classification System
Measurement period	January 1, 2025 - December 31, 2025
Performance Target	Case Performance Target set by ASC case rate for period July 1, 2023-June 30, 2024, by specialty group. ASC Case Rate = Total number of cases performed at ASC/Total number of cases performed in ASC OR hospital-based facility • Gastroenterology: 49% • General Surgery: 8% • Gynecology/Obstetrics & Gynecology: 4% • Ophthalmology: 92% • Orthopedic Surgery: 55% • Otolaryngology: 45% • Pediatric Urology: 15% • Plastic Surgery: 17% • Podiatry: 58% • Urology: 18%
Minimum Case Threshold	50 total eligible cases performed by given specialty
Eligible Members	• Gastroenterology • General Surgery • Gynecology/Obstetrics & Gynecology • Ophthalmology • Orthopedic Surgery • Otolaryngology • Pediatric Urology • Plastic Surgery • Podiatry • Urology
How to Meet the Measure	Complete the target case rate as a specialty group in an ambulatory surgery center.

MAMMOGRAM IMAGING CALLBACK RATES

Measure Objective	High-quality screening mammography has been shown to substantially reduce mortality from breast cancer. Mammogram imaging callback rate is a performance measure because it directly relates to the rate of false-positive examinations.[2] This measure intends to reduce variation in mammogram imaging callback rates thereby balancing the need to detect breast cancer while avoiding stressful and costly additional images.
Description	Maintain a callback rate, (i.e. the frequency that patients are asked to come back for additional images from screening) between 5% and 14%, which 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.
Numerator	Number of mammograms identified as needing additional imaging evaluation
Denominator	Total number of mammograms performed
Exclusion	N/A
Measurement period	January 1, 2025 - December 31, 2025
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

[2]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.

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 are associated with decreased mortality and improved patient outcomes. This measure intends 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 have 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).

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.

A. Measure lactate level
B. Obtain blood cultures prior to antibiotics
C. Administer broad spectrum antibiotics

If septic shock is present (defined by hypotension or lactate >=4 mmol/L), patients from the denominator who received all the following care elements 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 initialfluid resuscitation to maintain a mean arterial pressure >= 65 mm Hg)
F. In the event of persistent hypotension after initial fluid administration(MAP <65 mm Hg) or if initial lactate was >=4 mmol/L, re-assess volumestatus 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 legraise or fluid challenge
   - Focused exam including vital signs, cardiopulmonary, capillaryrefill, pulse and skin findings

G. Remeasure lactate if initial lactate is elevated.
H. Physician/Provider document above information to explain and support clinical decision making

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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 G) Pediatric patient population with sepsis or septic shock
Measurement period	January 1, 2025 - December 31, 2025
Performance Target	To be scored in **aggregate by facility** ≥70%
Eligible Members	Physician and 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

TURNAROUND TIME

Measure Objective	Timely reports are one of the most important tools physicians use to adequately manage the quality and safety of patient care. Turnaround Time (TAT) acts as a quality indicator to evaluate the effectiveness and efficiency of the testing process and the satisfaction of providers and patients
Description	**Pathology:** Average turnaround time for pathology report **Diagnostic Imaging:** Average turnaround time for radiology report
Numerator	Time from accession of specimen or study to signing of report
Denominator	Total number of orders
Exclusions	**Pathology:** Frozen section pathology reports **Diagnostic imaging:** Mammograms
Measurement Period	January 1, 2025 - December 31, 2025
Performance Target	**Pathology:** Breast, Cervical, Colorectal, Skin less than 72 hours. To be scored in HHP aggregate for all eligible members. **Imaging:** Average turnaround time less than 24 hours. To be scored in aggregate by facility.
Eligible Members	Dermatopathology, Diagnostic Radiology, Interventional Radiology, Neuroradiology, Nuclear Medicine, Pathology, Pediatric Diagnostic Radiology
How to Meet the Measure	Review and send appropriate test within specific timeframe

VERMONT OXFORD NETWORK (VON) FOR VERY LOW BIRTH WEIGHT (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."[3] This measure uses the VON VLBW and Expanded database to optimize clinical management of sick newborns.
Description	Credit earned by an eligible physician and provider under the VON measures VLBW and expanded database patients • VLBW – Nosocomial infection • VLBW – Any human milk by discharge to home • VLBW – Death or morbidity • Expanded – Nosocomial infection • Expanded – Any human milk by discharge to home • Expanded – Mortality excluding early deaths
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, 2025 - December 31, 2025
Performance Target	Top quartile for each of the 6 measures Partial credit will be given for being in the top quartile for less than 6 measures
Eligible Members	Neonatologists and Pediatric – NICU physicians who are members of the Hawai'i Pacific Health Medical Group Division of Neonatology

[3]From https://public.vtoxford.org/who-we-are-overview/. Retrieved 11/15/2024.

BONUS MEASURES

HHP NETWORK ENGAGEMENT – PRESENTER

Measure Objective	Physicians and providers are the cornerstone to making health care transformation work. Your involvement and engagement in HHP activity is critical to our success. This measure encourages and provides opportunities for information sharing and engagement with HHP members.
Description	Present at a HHP 2025 webinar
Exclusions	N/A
Measurement Period	January 1, 2025 - December 31, 2025
Eligible Members	All HHP credentialed members
How to Meet the Measure	**Present at a webinar:** Presenters at HHP webinars are eligible to earn credit if they attest to at least 2 hours of work in preparation for the presentation or/if continuing medical education credit was offered.

PARTICIPATION IN HHP CLINICAL WORKGROUPS & COMMITTEE LEADERSHIP

Measure Objective	HHP prioritizes care delivery concepts, including community health, quality, care coordination, and healthcare affordability, that are often difficult to incorporate into our traditional healthcare workflows. The intent of this measure is 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. An appointed member or chair of an HHP Committee offers a unique service opportunity to improve the leadership and direction of the Accountable Care Organization (ACO) in areas around quality, affordability, and maintaining a strong physician/provider network.
Description	Participation in HHP-chartered clinical workgroups that promote HHP value-based care objectives or serving as an appointed member or chair for an HHP Committee
Inclusion	All HHP credentialed members
Exclusion	N/A
Measurement Period	January 1, 2025 - December 31, 2025
Performance Target	Active participation in workgroups as reflected by attendance of at least 75% of meetings and demonstration of meaningful participation
Eligible Members	All HHP credentialed members
How to Meet the Measure	Physicians and providers, please refer to the relevant job descriptions listed below.
Workgroup Chair Job Description	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).

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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.

Workgroup Member Job Description

Credit earned will be determined by meaningful participation and contribution through attendance of at least 75% 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 physician/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 physician/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.

Committee Chair Job Description

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.

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Appointed Committee Member Job Description

Active participation in committee as reflected by attendance of at least 75% of meetings and demonstration of meaningful contribution of appointed member.

Credentialing Appointed Committee Member:

Actual, verifiable work is defined as the review and recommendation of quality materials and matters to the Board of Managers. Examples of this work are listed below:

- Regularly assess the adequacy of the network of HHP Network Physicians and Providers;
- Direct the Recruiting Subcommittee to actively recruit physicians and providers to potentially become HHP Network Physicians and Providers based on HHP's specific and identified needs;
- Ensure that the credentialing staff records the Committee's findings and recommendations and prepares a report for the Board for final approval;
- Ensure that credentialing staff notifies each reviewed physician or provider in writing and in a timely fashion of the Board's action with regard to such physician or provider's application.

Finance Appointed Committee Member:

Actual, verifiable work is defined as the review and recommendation of financial materials and matters to the Board of Managers. Examples of this work are listed below:

- Annual operating budget
- Policies that maintain and improve the financial health and integrity of the organization
- Long range financial plans for the organization
- Financial aspects for major transitions like the proposal to enter new or discontinue current payer programs and/or services
- Monitor financial performance against approved budgets and industry benchmarks
- Develop analyses and risk assessments related to payer contracts
- Financial aspects of the incentive programs to reward physicians/providers to become accountable for quality, cost, and overall care provided to HHP patients

Nominating Appointed Committee Member:

Actual, verifiable work is defined as the review and recommendation of quality materials and matters to the Board of Managers:

- Conducting appropriate inquiries into the backgrounds and qualifications of possible Physician Manager candidates;
- Ensuring that a Board leadership succession plan is in place;
- Developing a slate of Physician Manager candidates for election by the Physician Participants to fill Physician Manager positions;
- Providing nominations to the Board for officer positions that are expiring;
- Performing such other tasks related to the Board's recruitment and retention as the Board deems necessary or appropriate.
- At the completion of the nominations process, the Committee, as a whole, will appoint new members to the HHP Board of Managers and nominate Board Officers.

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Appointed Committee Member Job Description

Quality and Clinical Integration Appointed Committee Member:

Actual, verifiable work is defined as the review and recommendation of quality materials and matters to the Board of Managers. Examples of this work are listed below:

- Based upon relevant quality, utilization, and efficiency data analysis and evaluation, propose projects to enhance the quality of care for physicians and providers.
- Review regular quality reports and trends to identify trends and opportunities for improvement.
- Implement evidence-based practice guidelines or collaborative health care processes for issues including but not limited to key chronic conditions, preventive services, and other high-cost diagnoses and episodes of care.
- Actively solicit physician and provider feedback on quality measures including but not limited to protocol adherence, care and disease management programs, and patient centered medical home design and practice expectations.
- Review and assess individual physicians and providers' quality results and offer strategies to support improvement and growth.
- Make recommendations related to adopting technology to support physicians and providers.
- Develop strategies to improve clinical integration across members of the network.
- Develop strategies to ensure patient participation in the clinical care process and take accountability for their individual health and wellness.

ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	O'AHU	BIG ISLAND	KAUA'I	LĀNA'I	MAUI
PRIMARY CARE					
APRN (Family Medicine)	39%	20%	61%		
Family Medicine	39%	20%	61%	53%	
General Practice	65%		65%		
Internal Medicine	55%	27%	65%		
Pediatrics	58%	40%	56%		58%
Physician Assistant (Internal Medicine)			65%		
SPECIALIST					
Adolescent Medicine	65%				
Allergy & Immunology	65%				
Cardiac Electrophysiology	65%				
Cardiology	65%		65%		
Cardiothoracic Surgery	65%				
Colon & Rectal Surgery	65%				
Critical Care Medicine	65%				
Dermatology	65%				
Developmental-Behavioral Peds	65%				
Diagnostic Radiology	48%		65%		
Emergency Medicine	64%		29%		
Endocrinology	65%				
Gastroenterology	57%		48%		
General Surgery	65%		56%		
Geriatric Medicine	57%				
Gynecologic Oncology	65%				
Gynecology	65%				
Hematology/Oncology	65%		65%		
Hospice & Palliative Medicine			65%		
Hospitalist – Family Medicine	64%				
Hospitalist – Internal Medicine	65%		62%		
Hospitalist – Pediatrics	65%				
Infectious Disease	65%		65%		
Interventional Cardiology	65%				
Interventional Radiology	53%				
Maternal & Fetal Medicine	65%				
Neonatology	65%				
Nephrology	65%				
Neurology	65%		65%		
Neuroradiology	65%				
Neurosurgery	65%				
Obstetrics & Gynecology	65%	34%	51%		
Occupational Medicine	65%				

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APPENDIX

ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

CLINICAL PRACTICE AREA	O'AHU	BIG ISLAND	KAUA'I	LĀNA'I	MAUI
Ophthalmology	65%				
Orthopedic Surgery	61%		65%		
Otolaryngology	65%		65%		
Pain Management	65%				
Pediatric – NICU	33%				
Pediatric Cardiology	65%				
Pediatric Critical Care	65%				
Pediatric Diagnostic Radiology	65%				
Pediatric Emergency Medicine	65%				
Pediatric Endocrinology	65%				
Pediatric Gastroenterology	65%				
Pediatric Hematology/Oncology	65%				
Pediatric Infectious Diseases	65%				
Pediatric Nephrology	65%				
Pediatric Neurology	65%				
Pediatric Ophthalmology	65%				
Pediatric Orthopedic Surgery	65%				
Pediatric Pulmonology	65%				
Pediatric Rheumatology	65%				
Pediatric Sports Medicine	65%				
Pediatric Surgery	65%				
Pediatric Urology	65%				
Pediatrics	64%				
Plastic Surgery	65%				
Podiatry	65%		65%		
Post-Acute Long-Term Care	35%				
Pulmonology	65%				
Radiation Oncology	65%		65%		
Reproductive Endocrinology/Infertility	65%				
Rheumatology	65%				
Sleep Medicine	65%				
Sports Medicine	65%		65%		
Urgent Care/Walk-In	65%		59%		
Urogynecology & Pelvic Reconstruction	65%				
Urology	65%		65%		
Vascular Surgery	65%				
Weight Management	65%				
Wound Care	8%				

ECOSYSTEM THRESHOLDS BY CLINICAL PRACTICE AREA

Physicians and providers can meet the performance target through an annual meeting with the Medical Director. These meetings will be scheduled by the HHP team.

Physicians and providers whose CPA does not have qualifying baseline data	**O'ahu**	**Big Island**	**Kaua'i**
Anesthesiology	✔		✔
Child & Adolescent Psychiatry	✔		
Clinical Psychology	✔		
Dermatopathology	✔		
Hospice & Palliative Medicine	✔		
Pathology	✔	✔	✔
Pediatric Anesthesiology	✔		
Pediatric Physical Medicine & Rehab	✔		
Psychiatry	✔		
Pulmonology			✔
Physicians and providers with less than 10 claims			
Physicians and providers who are new to HHP in 2025			

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CREATING A HEALTHIER HAWAIʻI