Provider Perspective

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Bipolar I & II in primary care

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The integrative relationship of provider and payor
a prelude to the medical trialogus
By: Timothy P. Donelan, MD

New beginnings can be stressful and enriching at the same time. As we navigate the complexity of the health care marketplace, turbulent with instability from the federal level down, we can reflect that an enduring agreement will continue to exist in the relationship of the patient (or member), provider and the payor. I call this relationship a trialogus. This is Latin for a conversation between three people. Over the next several months, I will revisit this triad to assist in furthering the discussion on the best solutions for all seeking health care.

The historical evolution of this relationship will be subject to another discussion, but suffice it to say, the three of us will be coordinating at a level unprecedented in modern times. Employers seeking insurance require ever more advocacy as well as medically proven best practices in an environment of greater transparency and value. My future correspondence will center on this construct and I hope you enjoy the thoughts that it may bring. Please watch for future feature topics under the trialogus, which will always place the discussion in a patient or member-centric way with providers and payers as facilitators in the delivery of that care.

Are we at a historical time to reconfirm and clarify this relationship? If you answered yes, you may be wondering where things are really going. If this is a new beginning in health care, it might be best to define the concept of population health, a frequently used buzzword in today’s health care circles.

The walk you are taking is creating the structure for population health, whether you realize it or not. Your offices may be having team meetings, huddles, and gap score reduction strategy sessions. You may be hearing about bundled payments and other alternative payment models. You may be hearing about performance (dis) incentives and attribution strategies. If you hear these things, it is in part our walk due to the change towards population health.

Possibly best said by Kindig and Stoddart (2003), population health is defined as “an approach [that] focuses on interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.” Translation: Big data applied to patterns in human behavior with extreme levels of care coordination, increased efforts in patient engagement, standardization of best practices, elimination of duplicate or unnecessary services, and eventually reduction in total cost of care with no loss in quality. The American people have spoken, not only themselves, but through their employer based insurance representatives.

Data varies, though a 2015 CMS based article indicates the American medical spend at $9,990 per person while the average Swedish spend was around $6,500 per person [1].
Higher spending appeared to be largely driven by greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions. In contrast, US spending on social services made up a relatively small share of the economy relative to other countries. Despite spending more on health care, Americans had poor health outcomes, including shorter life expectancy and greater prevalence of chronic conditions [2].

Going back to the Trialogus, if the three of us were sitting at the kitchen table in a discussion on population health with the goal of raising the value and quality of the care while lowering total cost of care, our altruistic pop health-themed thoughts might be the following:

- Advocating to decrease health disparities
- Developing policy to address health disparities
- Improving health outcomes of populations in need
- Implementing cost effective strategies to address health disparities
- Enacting leadership strategies to impact safety, cost and clinical outcomes
- Executing educational approaches to improve clinical decision-making and evidence-based practice
- Developing practice guidelines [3]

To be fair, we would also include some oft-ignored advice:

- Stop smoking
- Stop using alcohol
- Lose weight
- Exercise/increase activity
- Invest in your health

If the above seems to be going on in your organization, you are heading into a pop health direction. Going back to the new beginnings question may be asking ourselves where we are in the greater discussion on value, the quality of services we bring to our patients, and special roles all three of us play in the delivery of health care. Challenges of this nature cannot be free of stress, but realize we continue at a steward’s level of commitment to making your work effective going forward.

Thank you for the service you provide our members.

Timothy P. Donelan, MD
Vice President, Medical Officer
Sanford Health Plan

References:

HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality. Quality improvement activities, health management programs and practitioner profiling efforts have all used HEDIS as a core measurement set.

Sanford Health Plan has published a HEDIS Provider Guide & Toolkit for your use. This guide is designed to assist providers in improving quality of care to members in alignment with HEDIS measures and evidence based clinical practice guidelines. View the HEDIS Provider Guide & Toolkit by logging in to your provider portal.

CLICK HERE

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Toward an accountable culture of safety

By: Steve Nelson, MD

“... The physician must be able to tell the antecedents, know the present, and foretell the future—must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm…”

Hippocrates, Of the Epidemics

Patient harm has been on the minds of physicians since classical antiquity. The benefits of medical and surgical therapies—and the unavoidable risks that are inherent in them—have been an inseparable reality of day-to-day medical practice for millennia. However, developing workflows that ensure patient safety and prevent avoidable harms has taken on a new urgency in recent years.

Methodological flaws have frustrated attempts to precisely quantify the impact of medical errors on patient morbidity and mortality; widely varying estimates can be found in the literature. Those flaws notwithstanding, it may be stated confidently that many patients die—and many others suffer preventable harms—each year as a result of medical errors (AHRQ, March 2017).

Although human error (as well as negligence) can occur, compromised patient safety often results from defective processes rather than flawed human beings. The “blame and shame” approach—that is, blaming individuals for process failures beyond their control, not only serves to perpetuate organizational secrecy around medical mishaps and frustrates the transparency required to address the defective processes effectively, but also contributes to provider burnout, depression and even suicide (IHI/ACHCE, 2017). Alternatively, a “no blame” approach may allow negligent behaviors to go unchecked. A more enlightened approach to enhancing safe practice is the creation of an organization that promotes a “just culture” of trust and accountability.

A useful blueprint for such an approach has been developed jointly by a partnership between the Institute for Healthcare Improvement, National Patient Safety Foundation, Lucian Leape Institute, and the American College of Healthcare Executives (IHI-ACHCE, 2017). This blueprint requires courageous senior executive and board leadership and consists of six leadership domains:

1. Establish a compelling vision of safety. Patient and employee safety is clearly defined as a core organizational value.
2. Build trust, respect and inclusion to foster transparency and accountability.
3. Select, develop and engage the board to enhance governance oversight of meaningful and actionable safety metrics. (See, for example, AHRQ PS Net “Measurement of Patient Safety”, June 2017)
4. Prioritize safety in the selection and development of leaders, such that safety is part of the organizational DNA at every level.
5. Lead and reward a just culture in which there is identification of accountability and corrective action for flawed systems as well as individual recklessness.
6. Establish organizational expectations for behavior expectations, or “The Way We Do Things Around Here.”

The document provides detailed, evidence-based strategies, tactics, and self-assessments to further the ultimate goal of “zero harm to patients, families and the workforce.”

Steve Nelson, MD
Senior Director, Medical Services
Sanford Health Plan

References:


Additional resources

- The Center for Medicare and Medicaid Services hospital comparison rankings—including safety domain scores—are available at Medicare.gov Hospital Compare https://www.medicare.gov/hospitalcompare/search.html?##.

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Behavioral health quick reference cards

As you know, clinical depression is one of the most common mental illnesses and is the second leading cause of disability worldwide. Depression is a serious, but treatable, medical condition that can cause people to disengage with their daily lives, complicate and interfere with treatment of other medical conditions, or become deadly if left untreated. As a health plan, we have implemented steps to encourage our members to seek effective treatment upon diagnosis and continue that treatment to ensure a healthy, productive life.

Because the primary care practitioner is most often the first (and perhaps only) place that people seek help, Sanford Health Plan has provider tools for these encounters. This information is also available to neurologists, psychologists and counselors to assist in the referral process. These tools include Quick Reference Behavioral Health Cards, which list behavioral health care providers in your region available for referrals. We ask you to consider these as resources for patients that come in with symptoms of a mental health or substance use disorder. Sanford Health Plan has resources and screening tools available on depression, anxiety, ADHD and bipolar disorder.

Quick Reference Cards are available for the following regions:

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Sanford Health Plan also provides the following services:

- Antidepressant member education letters to those who have started antidepressant medication and missed a refill.
- Contact by a Health Plan Behavioral Health Counselor upon a member’s discharge from an inpatient hospital or other facility for mental health or substance use, to ensure that follow-up appointments are arranged and prescriptions are filled as prescribed.
- Employee Assistance Program (EAP) offered to participating employer groups to assist in managing utilization of behavioral health services.

Quick Reference Behavioral Health Cards and other tools are available online. CLICK HERE.

Utilization management

The goal of Sanford Health Plan’s Utilization Management program is to encourage the highest quality care from the right provider in the right setting. We aim to ensure that provided services are medically necessary and in compliance with the benefits of the plan.

Utilization Management makes their criteria available – just call or email to request. Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage. Sanford Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to UM decision makers do not encourage decisions that result in under-utilization and do not encourage denials of coverage or service. Decision makers sign an “Affirmative Statement Regarding Incentives” verifying the above conditions.

There are several options for requesting prior authorization through Utilization Management. You can use your secure mySanfordHealthPlan account, phone or fax.

For full instructions on how to request prior authorization, please visit our website. CLICK HERE.

All requests for certification must be made at least three business days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three business days, contact Utilization Management to request an expedited review. The member is ultimately responsible for obtaining prior authorization. However, information provided by the provider’s office also satisfies this requirement.

If you have a question about decisions or the criteria used in decision making, contact Utilization Management and/or Vice President, Medical Officer between 8 a.m. and 5 p.m. CT, Monday through Friday. After business hours, you may leave a confidential voicemail and we will return your call.
The preventive health guidelines and new immunization schedules for children and adults are available online. CLICK HERE.

Thank you for your help in ensuring our members receive these important services. We believe that health promotion and disease prevention are valuable tools in the detection and treatment of preventable illnesses. Contact Provider Relations for a printed copy.

Points to remember:

• Prior authorization is not required for in-network providers providing care within preventive guidelines
• Annual services are allowed one time per calendar year, and are not required to be spaced 12 months apart
• Services performed outside of these guidelines, and with a medical diagnosis, will be applied to member’s deductible and coinsurance
• Preventive services are provided to members as listed unless otherwise stated in the member’s plan document (i.e. Summary Plan Description, Policy, Certificate of Insurance)

Some insurance companies do not allow members to obtain immunizations prior to their birthday, and there has been some confusion regarding our policy for immunizations. Sanford Health Plan allows immunizations for members to be done within the calendar year.

Prior authorization

Prior authorization is the urgent or non-urgent authorization of a requested service prior to receiving the service. During the prior authorization process, members and providers work together to get approval from Sanford Health Plan to provide coverage for specific procedures, medications or durable medical equipment. Sanford Health Plan’s decision is based on a combination of medical necessity, medical appropriateness and benefit limits.

Remember

• Prior authorization is never needed for emergency care.
• All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.
• Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an Out-of-Network facility will be denied unless authorized prior to being incurred.

Services requiring prior authorization

The Sanford Health Plan prior authorization list is based on our commercial plan and is subject to change based upon Sanford Health Plan Medical Management Policy updates. Please note that authorization requirements for other plans offered by Sanford Health Plan may vary slightly. Contact the Sanford Health Plan UM Department for additional information.

Notable changes effective 3/14/18

➢ Require prior authorization
  • Tissue Engineered Skin Substitute
➢ Removed from prior authorization list
  • Hospice services  • Home sleep study

CLICK to view the full prior authorization list.
Recognizing bipolar I and II symptoms in the primary care setting

As primary care providers you often attend to not just the medical, but also behavioral health issues. Bipolar disorder is not only a complicated, but challenging condition that may be difficult to diagnosis and treat. Patients with bipolar disorders are often left undiagnosed due to overlapping symptoms with other mental illnesses.

Time commitment, medication management and cost of care can make managing a bipolar diagnosis complicated. Due to limited availability of psychiatric services, individuals with a bipolar diagnosis tend to receive treatment and management from their primary care provider. When the individual is diagnosed with bipolar, proper treatment and care provides a better chance of controlling the illness and improving the quality of life. Treatment for bipolar is best guided by a medical doctor that specializes in mental health conditions (psychiatrist or psychiatric nurse).

Mayo Clinic defines bipolar I and II disorders as:

- **Bipolar I disorder**: Patient has had at least one manic episode that may be preceded or followed by hypomanic or major depressive episodes. In some cases, mania may trigger a break from reality (psychosis).
- **Bipolar II disorder**: Patient has had at least one major depressive episode and at least one hypomanic episode, but has never had a manic episode.

It is important to remember that bipolar I and II may present with different criteria for manic, hypomanic or major depressive episodes. The symptoms can create a noticeable change in normal daily routines, activities, work, school or relationships. Minnesota Multiphasic Personality Inventory (MMPI) is a helpful tool for primary care providers to recognize symptoms of bipolar I and II. Below is a list of criteria for each area of the bipolar diagnosis:

**Symptoms of manic and hypomanic episodes:**

- Abnormally upbeat, jumpy or wired
- Increased activity, energy or agitation
- Exaggerated sense of well-being and self-confidence (euphoria)
- Decreased need for sleep
- Unusual talkativeness
- Racing thoughts
- Distractibility
- Poor decision-making — for example, going on buying sprees, taking sexual risks or making foolish investments
- Bipolar I and II disorders may include other features, such as anxious distress, melancholy, psychosis or others

**Symptoms of major depressive disorder:**

- Marked loss of interest or feeling no pleasure in activities
- Significant weight loss when not dieting, weight gain, or decrease or increase in appetite (in children, failure to gain weight as expected can be a sign of depression)
- Either insomnia or sleeping too much
- Either restlessness or slowed behavior
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Decreased ability to think or concentrate, or indecisiveness
- Thinking about, planning or attempting suicide

Knowing the symptoms can guide you to make proper referrals to behavioral health providers. It is possible for a primary care provider to effectively manage a patient with bipolar after diagnosis if a behavioral health provider is not available to manage the condition routinely. Effective management of the bipolar disorder increases the chance of the treatment plan succeeding and provides the best care for patients.

Specialty Referrals

If a Sanford Health Plan member requires a specialist, and the practitioner they request is unavailable, please assist them by offering alternative options. Often times a similar specialist may offer services right in your own clinic. In those instances, we ask for your assistance in offering these patients the option to see other like specialists in your clinic. If your specialist is unavailable and you do not have other options available in your clinic, please refer that patient to Sanford Health Plan Customer Service Department and our team can assist the patient in finding an alternate practitioner.
Timeliness of care

Sanford Health Plan takes pride in ensuring our members have proper access and availability to quality health care providers. We feel it is important to monitor the established policies and procedures of Plan participating providers to ensure member access to medical care and services is timely and appropriate. The criteria for appropriate access and availability included in these policies is available HERE.

To measure compliance with the NCQA required standards, Sanford Health Plan sent a paper survey to a sampling of network providers. The survey sampled:

- Three percent of Primary Care providers
- Five percent of Behavioral/Mental Health and/or Substance Use disorder prescribing and non-prescribing providers
- Five percent of Maternity/OBGYN providers
- Five percent of High-Volume Specialty providers (excluding maternity/OBGYN since this is assessed in a separate sample)
- Five percent sample of High-Impact Specialty providers (excluding maternity/OBGYN since this is assessed in a separate sample).

The survey asks what appointment options were available for patients with emergent, urgent and routine needs, as well as coverage for after hours and on-call providers. Specialty standards applied to each type of high volume and high impact specialty noted in the definitions. Congratulatory letters were sent to those clinics meeting the standards. Letters were also sent to clinics not meeting the standards, and action plans were requested from them. Sanford Health Plan Provider Relations follows up with these clinics after three months to measure compliance with the failed standard(s).

There were no access related member complaints or appeals in the last year. CLICK HERE for full survey results.

Clinics and participating providers will continue to receive education regarding the standards through the provider newsletter. All clinics in the survey received follow up letters with their clinic’s results as well as a copy of the Plan’s access standards. The clinics that failed to meet the appointment access standards were asked to create an action plan. Clinics are informed that members must be able to make appointments. Clinics must make accommodations if and when schedulers are unavailable.

Medical guidelines now available online

Milliman Care Guidelines (MCG) medical guidelines are now available through our provider portal and via Cite for Guideline Transparency (CGT) under ‘Medical Guidelines’ tab. With CGT, Sanford Health Plan is able to share clinical indications with providers. This web-based tool operates as a secure extension of our existing MCG investment for medical necessity determinations. CGT will provide you access to specific guidelines used for determinations, via secure portal access and password, as well as display selected guideline elements including clinical indications and evidence summary. Providers are required to sign in and receive a passcode each time they access CGT. Sanford Health Plan’s own developed medical guidelines and add-on addenda will be available outside of the CGT tool, but still within the mySanfordHealthPlan portal. We are excited to be able to offer this to our providers. Contact us with questions on how to use CGT.

Clinical practice guidelines

The Sanford Health Plan Physician Quality Committee has adopted new clinical practice guidelines. The complete listing of adopted guidelines is available on our website.