The Promise of Integrated Care:
Population Health 2.0

By: Timothy P. Donelan, MD

Our nation’s varied but ongoing challenges around health care integration processes brings a lot of attention to the responsibilities we all have in the future of health care delivery. The alignments necessary to be successful and the service model to the employers and members we serve are highlighted in this article. The eventual “lift” to bring all this together requires the payer understands the clinical work that is paid for, as well as the recognition of the value that the clinician and their teams bring to these members.

One specific area to emphasize now, and more into the future, is the concept of direct primary care and the value of access with additional coordination in mental health, substance abuse and other primary care services. Payers are increasingly looking towards these core foundational services as the needs of the population changes. It comes as no surprise that integrated care produces the best outcomes and the most effective approach to caring for people with complex health care needs. Our future value based contracting will reflect strongly on the principles of the above idea. The team-based care continuum, along with care management with equal vigor, will head us all in the right direction. Theoretically, the only consistent variable in this situation will be the behaviors and level of engagement of the patient. The core of foundational success for all is the recognition of behavioral medicine and frankly, behavioral economics.

A recent SAMHSA integration program enrolling 170 people with mental illness revealed integration works. The program identified social barriers and brought solutions resulting in 50 fewer hospitalizations, 17 fewer emergency room visits and over $2.5 million in savings over a one-year period. Mostly it resulted in improved lives. Integration works. Data driven integration and risk/share agreements promise to provide opportunities for care teams to excel in the future, and health plans are more than willing to collaborate on these types of initiatives.

Most delivery systems are earnestly working towards the coming realities around data driven interventions that serve the members before utilization. The expectation is that preventive services, as well as other common quality metrics, will be measured as the standard-bearer in the walk to high quality. This concept could be viewed as a form of Population Health Version 1.0 and is familiar to us all.

It involves identification and stratification of the right patient and service compliment to assist them in their health care needs. This compliment of services aligns with the clinician’s role as diagnostician and treatment planner. This is not new, but the core of any contract will assume these responsibilities. The health plan’s role will ensure the benefit aligns toward achieving that goal. After this core quality content, will be total cost of care overlay models as well as more qualifying metrics that reward the team-based care models in complex care management.
What needs to be stated is that the journey of a thousand miles takes not only a first step, but also many more steps. Similar to the clinical side, on the health plan side, steps are being thoughtfully reviewed as Population Health 2.0 is evolving. The common quality metrics I recall as a clinician were around Minnesota measures, MIPS, HEDIS® and the often-mentioned areas like diabetes, vascular, and immunization rates. The future will drive more focus towards mental health, depression remission rates, health literacy, as well as care management and synergy to reduce emergency room visits. A large portion may include metrics around integrative collaboration and responsiveness to the value based contracts. These conversations cannot happen without foundational understanding in shared risk and goals that bring us all together.

One only needs to look at the NCQA standards published every September to understand that the push is to reward collaboration in communicating and achieving common goals to all three stakeholders: clinicians, members (patients) and payers. Population 2.0 is the bi-directional and real time communication between patient, providers and payers. The simple essence of real time knowledge, the same information at the same time with the same understanding. This makes Population Health 2.0 come together.

As valued partners in health care, the clinicians and systems that strive to bring the fully unfettered level of integrative energy as described above will bring value that will create a complete economic circle that everyone can be proud of. The most important thing will be the consistency and efficiency of these models from the viewpoint of the valued member who we are all in service to. The centricity around the patient is the core value to never lose focus of.

In summary, the payer is looking to an exciting time of change that will bring our mutually agreed upon metrics of quality to the evolving concept of value based contracting. It has been our mission to understand the standards of high quality care, and to benchmark this and provide service and a benefit design that assists the success of the care model wherever your vocation is located.

The customization potential of the common goals we all seek will come to be top of mind, as the power of systematic collaboration will merge with the common goals. This will fuel the success of your practices and achieve the market sensibilities to sustain the varied care models into the future.

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

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**HEDIS® Results**

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 the performance of managed care health plans. These annual HEDIS results are used in scoring Sanford Health Plan for NCQA accreditation.

We would like to highlight the most notable areas in this year’s results and share a few observations. While Sanford Health Plan has seen many increased rates this year, there are still a number of areas where improvement can be made.

**View results and areas of focus**

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Patient Safety: A Milestone on the Journey to Value
By: Steve Nelson, MD

According to the Commonwealth Fund, among 11 high-income countries, the US health care system is the lowest performing despite being the most expensive.1

NPR and ProPublica report that the US has the worst rate of maternal deaths in the developed world.2


According to the latest available data, the US ranked 31st in infant mortality among 34 Organization for Economic Cooperation and Development (OECD) countries, just below the Slovak Republic, and just above Chile, Turkey and Mexico.4

The journal Health Affairs has reported that despite greater per capita health care spending, the US has poorer child health outcomes than 19 other wealthy member nations in the OECD.5

The Minneapolis Star Tribune (Feb 22, 2018) reported that in the year ending in October 2017, hospital adverse reportable events (which the article characterized as “never events”) in Minnesota increased from 336 to 341 events which contributed to 12 deaths and 103 disabling injuries. According to the article, only six states publicly report adverse events.6

Clearly, we’re paying more for health care and getting less—a lot less. How do we begin to get our arms around this?

A good place to start would be by defining patient-centered health care value: it’s typically defined as:

**Quality/Cost**
Where Quality = outcomes + patient experience, and cost = direct costs + indirect costs.7

If you think about it, patient safety significantly impacts each of these variables, for better or for worse. And because safety impacts outcomes, patient experience, direct and indirect costs, safety profoundly affects patient-centered health care value. So health systems can improve health care value by improving patient safety. How can safety be improved? Strategies and tactics to improve safety abound in the literature. One such strategy is “just culture.”

“Just culture” is midway between two extremes, namely the “blame and shame” culture in which the people involved in the medical errors are identified and punished, regardless of circumstances, and the “it’s not people, it’s process” culture in which systems (rather than people) are the subjects of scrutiny, and as a result, people are not held accountable for improper actions.

The “Four Parameters” of Just Culture8 are:
1. A recognition that competent professionals make mistakes in complex systems
2. Even competent professionals will develop unhealthy norms
3. (Just Culture has) Zero tolerance for reckless behavior
4. (Just Culture) Balances a non-punitive/blame free environment with accountability.

Third parties can’t directly dictate health system culture but can incent providers to broaden safe practice through data transparency and payment reform. In order to accomplish this, reliable safety data is needed. As data analytics capabilities improve, “Never Events” and “Hospital Acquired Conditions” will be identified more readily.

Once reliable and actionable data become available, we can begin to move away from fee for service (FFS). Historically, the traditional FFS “production” model has contributed to waste and unnecessary care. It dis-incentivizes health maintenance and there is no link of payment to value and thus no link to patient safety. With good data, innovative alternate reimbursement models like bundled payments, capitation, shared savings, pay for performance and population-based payments (all closely tied to value) will be explored and expanded, ultimately banishing FFS to the ash heap of history.

CMS is already doing this. Thanks to health care reform, we are now witnessing the evolution of Accountable Care Organizations, policies that penalize hospitals for high rates of readmission and hospital acquired conditions, bundled payments and MACRA (Medicaid Access and CHIP Reauthorization ACT). MACRA includes MIPS (Merit-Based Payment System) and the Alternate Payment Model (APM).9

Sanford Health Plan can raise awareness about patient safety by directing members, employers and providers to a multitude of resources.

First, CMS publishes Hospital Compare and the Overall Hospital Quality Star Rating which are readily available to the public. Hospital Compare is organized into several domains: mortality, safety, readmission, patient experience, effectiveness of care, timeliness of care,

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1. Commonwealth Fund
2. NPR and ProPublica
3. Unicef
4. OECD
5. Health Affairs
6. Minneapolis Star Tribune
7. Quality/Cost
8. Just Culture
9. MACRA
Continued from previous page.

and efficient use of medical imaging. The Quality Star Rating aggregates all these data in a way that’s more user friendly for the general public.

Second, independent rating organizations, including Consumer Reports, Leapfrog, Healthgrades, TJC and several others, regularly publish quality and safety data.

And finally, taking patient-centered health care value seriously is not for the faint of heart. We’ll have to take a hard look at how we design our networks to make certain that members are directed to providers on the basis of both quality AND cost.

So, while we’re awaiting the data, we’ll continue to think about alternate payment models, develop a consistent message about the impact of safety on value, direct our members and providers to quality ratings resources, and restructure our networks accordingly.

This is not going to be easy. The move from FFS to value-based reimbursement will require providers to invest upfront in infrastructure that may not be reimbursed immediately, and network restructuring will take courage.

There will be inertia to move away from the status quo. Pushback should be expected. But we have before us the opportunity of a lifetime—a chance for all of us to play a role in the transformation of health care that could last a lifetime, or two.

Steve Nelson, MD
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Sanford Health Plan

References:
2 https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger
3 Source: https://www.unicef.org/media/media_102477.html; and United Nations Inter-agency Group for Child Mortality Estimation, 2017
8 http://coorshealthcaresolutions.com/what-is-a-just-culture/

2018 Patient Safety Goals According to The Joint Commission

Patient safety has been defined as “the prevention of harm to patients.” With that definition, we must now do what we can to prevent errors, learn from the errors that do occur, and build on a higher culture of safety that not only includes the health care professionals, but also the patients and the organization.

Setting goals for your department, clinic or organization is a great way to start improving on safety. Such goals will not only help keep your patients safe, but you and your staff as well.

Goal 1: Identify Patients Correctly
- Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct treatment and/or medicine.

Goal 2: Improve Staff Communication
- Make sure test results are delivered to the correct staff person on a timely basis.

Goal 3: Prevent Infections
- Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.
- Take extra care with patients who take medicines to thin their blood.

Goal 4: Improve/Build Patient Relationships
- Make patients, family members and providers work as partners.
- Treat the patient as a person. Welcome them into your world and orient them to their care process. Create a partnership by offering them empathy, respect, legitimacy and support.
- Shape the care plan to the patient. Explain why it may or may not include what they expected. Make sure they understand you by having them repeat your instructions.
Patient Safety Changes Effective for 2018

The Joint Commission has made changes for 2018 that related to multidrug-resistant organisms (MDROs) to now include carbapenem-resistant enterobacteriaceae (CRE) as one of the organisms covered by the goal, and the goal has been revised to allow organizations to determine the appropriate time frame for education.

They have also updated central line-associated bloodstream infections (CLABSIs) to show the elements of performance (EPs) for hospitals and critical access hospitals that have been reordered. The goal has been modified to allow organizations to determine the appropriate time frame for educating staff and licensed independent practitioners. Similar modifications were made for nursing care centers, and the requirement for the education of residents and patients has been added.

For more information on this topic, visit:

- The Joint Commission: Patient Safety
- The Joint Commission: Safety Standards
- Patient Safety: Achieving a New Standard for Care
- Institute for Healthcare Improvement
- Agency for Healthcare Research and Quality

Medical Record Documentation and Results of Audit

Each year, we review medical charts for HEDIS reporting, checking if general standards are met. For 2018, the three standards that had the lowest compliance rates out of the 17 total elements were:

- Personal biographical data that includes address, home and work telephone numbers.
- Immunization records for children are up to date or an appropriate history has been made in the medical record for adults.
- There is evidence that preventive screening and services are offered in accordance with the organization’s practice guidelines.

In an effort to continue high-quality care for our members, we want to remind you of the importance of accurate and complete clinical documentation. The absence of complete documentation within a patient’s record can negatively influence clinical preparedness, continuity of care, and financial planning for a patient’s treatment.

Why is complete medical record documentation important?

Each year, Sanford Health Plan completes a medical record documentation compliance audit. Records from both Sanford clinics and non-Sanford clinics are included in this review. The medical record documents the history of a patient’s health and is an important factor for high quality of care. A complete medical record supports:

- Physicians and other health care professionals in the evaluation and planning of a patient’s immediate treatment and the monitoring of a patient over time.
- The communication and continuation of care among physicians and other health care professionals involved with the patient’s care.
- Accurate and timely claims review and payment.
- Appropriate utilization review and quality-of-care evaluations.
- The collection of data that could be useful for education and research.

Are these items easily identified and up to date in your patient records?

This is the question to ask yourself and your organization when reviewing your own patient records.
Over the past decade a rising trend of opioid dependence, overdose, and poisoning have collectively become a national public health concern. According to the Centers for Disease Control, overdose deaths involving prescription opioids has quadrupled since 1999, as well as the sales of these prescription drugs.

The American Society of Addiction Medicine reports that drug overdose is the leading cause of accidental death in the US. Opioid addiction is driving this epidemic with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015. The increase in abuse, addiction and deaths can be attributed to the broad availability of opioids. This availability has risen due to the drastic increase in the number of prescriptions written, dispensed and growing acceptability in using opioids for different purposes.

Patients with pain control issues commonly seek care in primary care settings. With the complexity of controlling and managing patients with pain issues, it can be very time consuming for providers. Oftentimes in treating pain control issues, patients may also have behavioral health concerns that may need to be addressed. The difficulty for providers is finding pain management clinics and behavioral health providers.

To increase awareness about this issue and to provide support to our providers, Sanford Health Plan offers best practices information and tools for decreasing opioid dependence, admissions, readmissions and deaths.

- Complete a comprehensive evaluation and opioid risk assessment of the patient using the opioid risk tool (ORT).
- Develop a pain contract and treatment plan for patients who need to take opioids long term.
- Schedule regular follow up appointments with patients to ensure care is monitored and medication effectiveness/adherence. Ensure coordination and communication with all providers.
- Refer patients needing specialized services in pain management and behavioral health to specialists.
- Adhere to controlled substances laws and regulations of the Controlled Substances Act (CSA).
- Utilize the CDC’s mobile app or the Morphine Milligram Equivalent (MME) calculator.

Most states have prescription monitoring programs, which can be useful tools for providers to identify patients who are obtaining opioids from multiple prescribers, calculate the total amount of opioids prescribed per day, and identify patients who are being prescribed other substances that may increase risk of opioids – such as benzodiazepines.

For more information on state prescription monitoring programs, visit National Association of State Controlled Substance Authorities or the CDC.

Improving the way opioids are prescribed will ensure patients have access to safer, more effective chronic pain treatment while reducing opioid misuse, abuse and overdose.
End HPV Cancers
Take a Stand by Making Effective Vaccination Recommendations

The American Cancer Society announced Wednesday, June 6, 2018 that the organization is launching a public health campaign to eliminate vaccine-preventable HPV cancers, starting with cervical cancer. Their goal is to reach an annual vaccination rate of 80 percent of young people by 2026. It’s a daunting goal – but with the combined support of all the organizations working to improve HPV vaccination, it is possible.

As you may know, the human papillomavirus (HPV) causes six types of cancer and is a common infection. In fact, 9 out of 10 adults – both men and women – are infected with HPV at some point in their lives. Fortunately, we have a vaccine that will prevent this infection from ever occurring and therefore prevent many of the cancers it causes.

Nearly all cases of cervical cancer are caused by HPV. Through vaccination of young adolescents, and screening of women, we have the tools to eliminate cervical cancer. In the United States, 6 out of 10 of girls and boys aged 13-17 have started the HPV vaccination series, but only 4 out of 10 of girls and boys are up to date on getting the full series. We have a long way to go and we need your support.

This is an unprecedented opportunity to save lives and reduce the HPV cancer burden. HPV vaccines are proven to be safe, effective, and provide lasting protection, yet rates of HPV vaccination continue to fall far behind other adolescent vaccination rates, as seen in this table highlighting regional performance:

Series Completion of HPV Vaccination Coverage Compared to Tdap & MCV4, 13-17 years, National Immunization Survey-Teens (NIS-Teen), 2016

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<thead>
<tr>
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<th>South Dakota</th>
<th>North Dakota</th>
<th>Minnesota</th>
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<tbody>
<tr>
<td>Tdap</td>
<td>79%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>MCV4</td>
<td>65%</td>
<td>92%</td>
<td>85%</td>
</tr>
<tr>
<td>HPV</td>
<td>38.6%</td>
<td>52.7%</td>
<td>44.1%</td>
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</table>

What can you do to help end HPV cancers?

- Make sure your patients are vaccinated. For parent education materials, visit American Cancer Society.
- Find resources on making an effective recommendation for HPV vaccination. Resources available from ACS here.
- Watch for upcoming opportunities to be part of the effort to increase HPV vaccination in your community.

To see a world free of cervical cancer, we must act now. Will you take a stand to eliminate HPV cancers? For more information contact your local American Cancer Society office or visit them online.
Member Experience Survey Results

Sanford Health Plan strives to provide the best service we can to our members. CAHPS® (Consumer Assessment of Health Plans Study) 5.0H is the Plan’s member satisfaction survey that takes place on a yearly basis within our commercial population. A Qualified Health Plan (QHP) Enrollee Experience Survey is also conducted within our Marketplace population on an annual basis. These surveys are conducted by an independent survey vendor on a random sample of members and provide information on the experiences of our members and how well the Plan and its participating practitioners meet their expectations. We have provided a selection of CAHPS® scores which summarize survey responses in key areas related to our practitioners.

The Plan’s Quality Improvement Committee analyzed the commercial CAHPS® and Marketplace QHP Enrollee Experience Survey results and identified the areas that show the greatest opportunities for improvement. The Committee also determined activities that will be (or already are) implemented to achieve improvement. The highest priority intervention identified is to work on improving member and provider materials and the website/web portal. A focus group will be implemented to work with Member Experience on this project.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Tobacco Cessation and Quit Resources

It’s difficult to quit tobacco, but it’s easier with someone to help. There are many resources to help kick the tobacco habit for good. The state quit lines and the US Department of Health and Human Services offer guides and opportunities for counseling and medication therapy.

**Smokefree.gov**: [877] 44U-QUIT

**South Dakota QuitLine**: [866] SD-QUIT or [866] 737-8487

**ND Quits**: [800] QUIT-NOW or [800] 784-8669

**Iowa Quitline**: [800] QUIT-NOW or [800] 784-8669

**QUITPLAN (Minnesota)**: [888] 354-PLAN or [888] 354-7526

**SANFORD HEALTH PLAN’S SMOKING WELLNESS BENEFIT**

Treatment for tobacco abuse is covered as part of Sanford Health Plan preventive health benefits. These treatments include:

- Telephone, group or individual counseling is covered up to eight sessions per calendar year (two tobacco cessation attempts per year with four sessions allowed per attempt) at no cost to the member, without prior authorization.

- 90-day supply of any FDA-approved tobacco cessation medication, including prescription and over-the-counter medications when ordered by a health care provider are covered at no cost to the member and do not require authorization. This applies for each of the two attempts.

- Tobacco education is a covered benefit and would apply to deductible and coinsurance.

- Any other tobacco cessation services not listed may not be a covered benefit. Some of those services include hypnotherapy and acupuncture.

- Members can call Customer Service at the number listed on the back of their member ID card for further information.

**NDPERS PROGRAM**

Current employees, spouses and dependents age 18 and older with NDPERS health coverage, **employed by the State of North Dakota, North Dakota University System, district health units, and Garrison Diversion Conservation District** are eligible to receive the following tobacco cessation benefits through a North Dakota grant program:

- $200 for office visits and co-pays
- $500 for FDA-approved medications
  - Over-the-counter: Nicotine gum, patches or lozenges
  - Prescription: Bupropion, Chantix, nasal spray or inhaler

After eligibility is verified, the member will receive a debit card and welcome packet. They are able to re-enroll every six months and there is no limit on the number of times they can participate. Eligible members can go to [sanfordhealthplan.com/ndpers](http://sanfordhealthplan.com/ndpers) or call [877] 737-7730 to enroll or for more information.

**ADVISING TOBACCO USERS TO QUIT**

Sanford Health Plan received results from our 2016 CAHPS® 5.0H survey, including tobacco use measures. Sanford Health Plan has implemented various interventions in an effort to assist with smoking cessation. These efforts include making the quit line and Health Plan cessation benefit information available and including cessation information in our disease management program education. We also created a dedicated web page to smoking cessation education and resources.

Rates related to smoking/tobacco cessation are below. These are reported as two-year rolling average rates.

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<thead>
<tr>
<th></th>
<th>CAHPS® 2016</th>
<th>CAHPS® 2017</th>
<th>CAHPS® 2018</th>
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</thead>
<tbody>
<tr>
<td>Advising smokers/tobacco users to quit</td>
<td>77.69%</td>
<td>76.79%</td>
<td>70.65%</td>
</tr>
<tr>
<td>Discussing smoking cessation medications</td>
<td>43.80%</td>
<td>43.36%</td>
<td>51.61%</td>
</tr>
<tr>
<td>Discussing smoking cessation strategies</td>
<td>42.37%</td>
<td>40.00%</td>
<td>46.15%</td>
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Specialty Referrals

If you have a Sanford Health Plan member requiring a specialist, and the practitioner they are requesting is unavailable, please assist them by offering alternative options. There have been some instances where members need to be seen by a specialist, but that specialist is unavailable for a variety of reasons.

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 at (605) 328-6800 or (800) 752-5863 and our team can assist the patient in finding an alternate practitioner.
Contact us
Utilization Management and
Vice President/Medical Officer
(800) 805-7938 | um@sanfordhealth.org

Provider Relations
(800) 601-5086
providerrelations@sanfordhealth.org

Customer Service
(800) 752-5863
memberservices@sanfordhealth.org