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NCQA Special Edition – December 2019
Tapping the functional waste reserve in American health care

By: Timothy P. Donelan, MD

Recent parroting in the US press on the topic of waste sent negative reverberations into the national mindshare on where US health care stands as an industry. The debate harkens to a time my father used to say, “Waste not, want not.”

I had to reference the saying as I was thinking recently on the issues of elusive waste brought forward in an interesting article by former CMS Administrator Donald Berwick, MD, MPP—the former CEO of the Institute for Healthcare Improvement and former administrator of the Centers for Medicare and Medicaid Services. This was published in JAMA (October 7, 2019). The concept is simple to understand, as is the proverb, “Waste not, want not.” Application of this to the health care industry is not so simple. The roles of the clinician are integral in the movement to reduce change. Clinician understanding to what I call the functional waste reserve represents opportunity in your own practice environment to improve care and sustain care for the patients, communities and systems you serve.

If you use a commodity or resource carefully and without extravagance, you will never be in need. This is the basic premise of recent readings throughout the health care information exchange. It is vocalized in many ways, from many perspectives, with similar goals, but the end game is often how we cut waste.

So herein, lies the Fermi Paradox in US health care as reported by Dr. Berwick.

To simplify this concept, first it comes to the sobering numbers that evidence this waste. The estimates of total health care expenditure are exceeding $3.5 trillion. Waste estimates report 25 percent of this could be saved. $800 billion annual savings from waste reduction strategies is more than the 2019 Federal defense budget.

The thought of waste brings instant feelings to the deplorability of waste. Well, doctor (or administrator), it is not your resource. It is the public’s resource. The numbers take me back to Wisconsin Senator William Proxmire’s Golden Fleece awards, popular in the 1970s and 1980s. Though Proxmire used his office for tongue-in-cheek awards given to public officials for squandering public money, his efforts brought awareness to the problem of waste. The recent JAMA is doing the same thing. The thought of $800 billion brings forward the adage that America is becoming a very large insurance company with a formidable Defense Department. Though Proxmire used his office for tongue-in-cheek awards given to public officials for squandering public money, his efforts brought awareness to the problem of waste. The recent JAMA is doing the same thing. The thought of $800 billion brings forward the adage that America is becoming a very large insurance company with a formidable Defense Department.

As clinicians, we often view the way the body builds in a reserve for disease or infirmary. We have an extra kidney, a hepatic reserve and a functional reserve volume (FRV) in our lungs. The health care industry is a patient of its own sort. It has tremendous duplications, administrative burdens are rampant, and there is lack of interoperability, ongoing trust issues, misaligned incentives and lack of transparency. This entire disharmony reigns. All these issues “tap into the waste reserve,” that we cannot afford to squander.

Continued on next page.
The provider perspective today is for clinicians to understand the powerful role they can serve to eliminating needless waste. Waste is out there and we all have a part in eliminating it. Our patients deserve the best care with a resource stream that is reliable, accountable and there when it is needed.

In summary, Sanford Health Plan, recognizing its role to reduce waste, will be forward thinking to reduce the prior authorizations and your administrative burdens, to build out and understand the value of transparency, to align population health data and care management strategies and to create core strategies to work with providers to use resources wisely. If we are to live out the Hippocratic Oath of Primum non nocere or “First do no Harm,” then we should continue our vocational work with patients recognizing this directive, but also understanding that the value of waste elimination provides more resources to carry out our Oath. This brings me back to “Waste not, want not.”

Be well and be there for your patients, all of them, even the ones not in the office today.

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

HEDIS® Results

HEDIS (Health Plan 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 health care quality. HEDIS was developed by the National Committee for Quality Assurance (NCQA) and is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service.

HEDIS rates are part of Sanford Health Plan’s NCQA health plan accreditation score and are required by various state and federal regulatory agencies. HEDIS rates are also increasingly utilized in value based contracting arrangements.

We would like to highlight some of 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.

**CLICK HERE** for HEDIS 2019 Commercial HMO Rates.

Information on Plan programs to improve these rates is available in mySanfordHealthPlan Provider Portals.
CONTINUITY AND COORDINATION OF CARE

Sanford Health Plan believes that its Members should receive seamless and appropriate care across the health care continuum. The Quality Chasm is health care quality framework that addresses the necessity for better and improved care coordination. One of its ten rules calls attention to the necessity for provider communication and collaboration.

Cooperation among clinicians

• Clinicians and institutions should actively collaborate and communicate to ensure the appropriate use and exchange of information and coordination of care, which includes primary care, specialists and behavioral health specialists.
• Clinicians and patients should actively and effectively communicate and share information.

From a patient’s perspective, continuity of care is the experience of how care is coordinated. Continuity is associated with improvements in the quality of patient care and better health outcomes including higher satisfaction and lower hospitalization rates.

3 T’s to effective Continuity and Coordination of Care

• Teaching: Teaching self-care to patients and their caregivers helps reinforce practices in the home.
• Technology: Ensure smooth flow of information between primary care, specialists, including behavioral health specialists, using EHR’s to facilitate information sharing. Engage patient use of member portals allowing patients easy access to records, test results and other educational information.
• Transition: Plan for a structured and comprehensive discharge. Ensure patients have all follow-up appointments scheduled with their primary care or specialist.

To ensure all of a patient’s needs are met, it’s vitally important to talk to patients about possible barriers to their care. Patients may experience many different social determinants of health that affect their health outcomes. Transportation, food insecurities, paying for medications, employment and housing are just a few factors that impact your patients’ care outcomes. Talking with patients during appointments about social determinants of health is one way to ensure patients are able to adhere to their care plan and increase their health outcomes.

For more information on Continuity and Coordination and how to code for Social Determinants of Health, please see the Sanford Health Plan Provider Toolkit available in the mySanfordHealthPlan Provider Portal.

Updates

✅ Sanford Health Plan now has HEDIS Flipbooks available on our physician portal. LOG IN TO VIEW.

✅ The annual Timeliness of Care Surveys have been mailed. Please take a moment to make sure your front office staff completes these. This survey helps us better understand how we our doing with access to care and if more physicians, clinics or specialties are needed.

✅ The Physician Satisfaction Survey has come to a close. All the information is now being compiled and analyzed. Results will be available in the next Provider Perspective. Thank you to all who completed the survey.

✅ The Agency for Healthcare Research and Quality (AHRQ) has announced a new hospital toolkit for Antibiotic Stewardship. VIEW ONLINE HERE.
Medical Record Documentation and Results of Audit

Each year, we review medical charts for our HEDIS® reporting, checking to make sure that general standards are being met. For 2019, the three standards that had the lowest compliance rates out of the 17 total elements were:

• An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults
• Personal biographical data include the address, home and work telephone numbers
• 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.

HEDIS® 2020 & Telehealth

Telehealth is generally defined as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”¹ NCQA’s interest in telehealth relates specifically to the provision of clinical health care, including diagnosis, monitoring and treatment of conditions. In practice, telehealth is an option for both health care consumers and health care providers that want improved access to health services and greater scheduling flexibility. NCQA found evidence to support the use of telehealth as an appropriate method of satisfying the indicated measure elements. In the measures for which telehealth is recommended for inclusion, video conferencing, telephone visits and online assessments were found to be appropriate.

For HEDIS 2020, NCQA proposes the following:

• Include telehealth services in the following measures:
  – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).
  – Children and Adolescents’ Access to Primary Care Practitioners (CAP).

• Prohibit use of telehealth services in the following measures:
  – Well-Child Visits in the First 15 Months of Life (W15).
  – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34).
  – Adolescent Well-Care Visits (AWC).

To be responsive to the changing health care landscape as it relates to telehealth services, NCQA maintains four HEDIS telehealth value sets: Telephone Visits, Online Assessments, Telehealth POS and Telehealth Modifier. The Telehealth Modifier Value Set includes CMS GT modifiers and American Medical Association 95 modifiers that are to be used in conjunction with select CPT© and HCPCS billing codes to signify that a service was rendered via synchronous telehealth methods (interactive audio and video).

References:

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 experience 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/Exchange 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.

Below are the survey rates related to member experience with practitioners.

### Commercial HMO CAHPS® Personal Doctor and Specialists Overall Ratings

<table>
<thead>
<tr>
<th>Quantitative analysis</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Personal Doctor Rating</td>
<td>89.12%</td>
<td>82.76%</td>
<td>89.05%</td>
</tr>
<tr>
<td>Q15. Have a personal doctor</td>
<td>77.58%</td>
<td>78.46%</td>
<td>77.82%</td>
</tr>
<tr>
<td>Overall Specialist Rating</td>
<td>85.11%</td>
<td>82.35%</td>
<td>78.03%</td>
</tr>
<tr>
<td>How Well Doctors Communicate Composite Rate</td>
<td>96.92%</td>
<td>97.22%</td>
<td>98.00%</td>
</tr>
<tr>
<td>Q17. Doctor explained things - easy to understand</td>
<td>98.03%</td>
<td>99.03%</td>
<td>98.93%</td>
</tr>
<tr>
<td>Q18. Doctor listened carefully</td>
<td>96.55%</td>
<td>97.10%</td>
<td>98.40%</td>
</tr>
<tr>
<td>Q19. Doctor showed respect</td>
<td>98.03%</td>
<td>97.58%</td>
<td>97.87%</td>
</tr>
<tr>
<td>Q20. Doctor spent enough time</td>
<td>95.05%</td>
<td>95.17%</td>
<td>96.79%</td>
</tr>
<tr>
<td>Q66. How often you had a hard time speaking with or</td>
<td>100% (never - 93.41%; sometimes - 6.59%)</td>
<td>100% (never - 92.49%; sometimes - 7.51%)</td>
<td>100% (never - 92.49%; sometimes - 7.51%)</td>
</tr>
</tbody>
</table>

| Shared Decision Making Composite Rate                       | 83.45%  | 81.74%  | 84.75%  |
| Q10. Doctor discussed reasons to take a med                 | 94.24%  | 95.42%  | 95.04%  |
| Q11. Doctor discussed reasons not to take a med             | 77.70%  | 74.81%  | 84.43%  |
| Q12. Doctor asked what you thought was best                 | 78.42%  | 75.00%  | 74.79%  |
| Coordination of Care – Q22. Personal doctor seemed         | 80.17%  | 81.82%  | 86.32%  |

| Q23. Personal doctor seemed informed about care from other providers | 68.91%  | 75.19%  | 71.85%  |
| Overall Health Care Rating                                  | 74.63%  | 77.13%  | 76.15%  |

| Getting Needed Care Composite Rate                          | 86.48%  | 88.59%  | 87.02%  |
| Q25. Getting appointment with specialist as soon as needed | 81.94%  | 86.52%  | 81.16%  |
| Q14. Getting needed care, tests or treatment was easy       | 91.01%  | 90.66%  | 92.89%  |

| Getting Care Quickly Composite Rate                         | 83.68%  | 85.08%  | 86.11%  |
| Q24. Got urgent care as soon as needed                      | 87.18%  | 89.57%  | 94.17%  |
| Q6. Got regular/routine appointment as soon as needed       | 80.17%  | 80.60%  | 78.04%  |
Coding for acute bronchitis and possible comorbidities

The HEDIS® “Avoidance of Antibiotic Treatment” measure includes patients who were diagnosed with uncomplicated acute bronchitis and who were not prescribed an antibiotic. However, as you know, a patient who has a co-morbid condition, competing diagnosis and/or bacterial infection may require treatment of acute bronchitis with an antibiotic. It is critical that you use proper coding when prescribing an antibiotic for these patients. Proper coding will ensure that members with a co-morbid condition or competing diagnosis are excluded from the measure.

Use one of these codes to identify acute bronchitis:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM Diagnosis</th>
</tr>
</thead>
</table>

Make sure to add codes to identify co-morbid conditions, as applicable:

- Bronchiectasis
- Chronic bronchitis
- COPD
- Cystic fibrosis
- Disorders of the immune system
- Emphysema
- HIV; HIV Type 2
- Malignant neoplasms
- Other diseases of the respiratory system
- Pneumoconiosis and other lung disease due to external agents
- Tuberculosis

Add codes to identify competing diagnoses, as applicable, including, but not limited to:

- Pharyngitis
- Acute bronchitis
- Pneumonia
- Whooping cough
- Otitis media
- Sinusitis
- Tonsillitis
- Lymphangitis
- Bacterial infection

Great resources on antibiotic utilization can be found on the CDC website from their GETSMART campaign, AVAILABLE HERE.

Quality improvement year-end report

Sanford Health Plan and its participating providers are committed to providing high quality health care to our members. Below is a list of some of the Plan’s current quality programs.

Clinical Areas of Quality Improvement

- Population Health – New 2019
  - Promoting colorectal and breast cancer screenings for eligible members
  - Members with chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease and hypertension to:
    - Prevent health complications
    - Provide assistance in managing their health
    - Ensure their care is coordinated
- Diabetes Health Quality Improvement Activity
- Improving Antibiotic Utilization Quality Improvement Activity
- Increasing Timely Follow Up After Hospitalization for Mental Illness Quality Improvement Activity

Non-Clinical Areas of Quality Improvement

- Customer Service Phone Calls Quality Improvement Activity
- Timeliness of Care Quality Improvement Activity

For more information on all of the Health Plan’s Population Health or Quality Improvement programs and outcomes, view our HEDIS Report and QI program executive summary on our website at SANFORDHEALTHPLAN.COM or call (888) 315-0884 to request a copy.

Specialty Referrals

If a Sanford Health Plan member requires a specialist, and the specialist is unavailable, please assist them by offering alternatives. A similar specialist may offer services right in your own clinic. If specialists are unavailable, and no other options exist in your clinic, please refer that patient to Sanford Health Plan Customer Service at (605) 328-6800 or (800) 752-5863 and our team can assist the patient in finding an alternate practitioner.
Pharmacy Formulary Changes & Process

Sanford Health Plan maintains a formulary, or a list of covered medications, to promote clinically appropriate and cost-effective medication use. Providers may access the Sanford Health Plan formularies online HERE. Providers may also view a list of medications that require prior authorization or step therapy on this same page. Our pharmacy management team is available to assist with questions.

Sanford Health Plan’s Pharmacy and Therapeutics (P&T) Committee is responsible for adding medications to the formulary and at times may designate a medication as non-formulary. The committee may designate a medication non-formulary if the medication has been shown to be safe and efficacious, but does not provide additional clinical benefit over the covered options already available to our Members. Please note that medications deemed not covered due to benefit exclusion, lack of safety, efficacy, etc. may be reviewed through the benefit exclusion policy.

Requests for coverage of non-formulary medications will be reviewed for medical necessity. At least one of the following criteria requirements must be met for consideration of coverage for a non-formulary medication:

1. BOTH of the following criteria are met:
   - Medication is being used for an FDA-approved indication.
   - Member has tried and failed at least a 30-day supply of three (3) covered formulary alternatives to the non-formulary medication. If there are less than three covered formulary alternatives available, the Member will be required to try all formulary medications.

2. Member has clinical contraindications to all covered formulary alternatives [clinic notes documenting the contraindications must be provided].

3. There is specific clinical basis where the covered formulary medication(s) are not appropriate for this specific Member [clinic notes documenting the clinical basis must be provided].

The Formulary list has recently been updated as of 11/01/2019. The updated version is available online.
Contact Us:

CONTACT FOR: Eligibility & benefits, claim status, provider directory, complaints, appeals, report member discrepancy information

- memberservices@sanfordhealth.org
  - Customer Service
    - Monday-Friday, 7:30 a.m. to 5:00 p.m. CST | (800) 752-5863
  - NDPERS Customer Service
    - Monday-Friday, 8:00 a.m. to 5:30 p.m. CST | (800) 499-3416
  - ND Medicaid Expansion
    - Monday-Friday, 7:30 a.m. to 5:00 p.m. CST | (855) 305-5060

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

- pharmacyservices@sanfordhealth.org
  - Pharmacy (855) 305-5062
  - NDPERS Pharmacy (877) 658-9194
  - ND Medicaid Expansion (855) 263-3547

CONTACT FOR: Preauthorization/precertification for medical services

- um@sanfordhealth.org
  - Utilization Management (800) 805-7938
  - NDPERS Utilization Management (888) 315-0885
  - ND Medicaid Expansion Utilization Management (855) 276-7214

CONTACT FOR: Assistance with fee schedule inquiries, check adjustments & reconciling a negative balance, request explanation of payment (EOP), claim reconsideration requests, W-9 form, change/updating information, provider education

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

CONTACT FOR: Requests to join the network and contract-related questions and fee schedule negotiation

- sanfordhealthplanprovidercontracting@sanfordhealth.org
  - Provider Contracting (855) 263-3544

Hearing or speech impaired TTY | TDD (877) 652-1844
Translation Assistance for Non-English Speaking Members (800) 892-0675