Provider Perspective

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October 2017
As a physician practicing family medicine for 23 years, it was difficult at times to grade the quality of my teams’ care. Now, under today’s evolving payment models, with providers rewarded for the quality of care and efficiency, having good, actionable data becomes crucial on the front lines of care. Employers are asking questions based on the value of the services they jointly purchase from the medical industry. These questions can be answered best with data.

“Our goals are to assist providers in best practice & bring this quality via data to the bedside encounter.”

Having quality and outcomes metrics assisted me in patient care choices, ultimately leading to better outcomes. An example was the asthma gap scoring system we often used. Implementing the best practice around a key determinant in the care of asthma (the proper use of the inhalers as well as educating on the alerts to recognize asthma exacerbations) resulted in lower emergency situations and saved lives. How was I, as a physician, to know this without data on gaps in care, as well as a team, to close those gaps?

Risk stratification along with predictive intelligence using patient social determinants and patterns of medical utilization allows us to assist in “meeting the patients where they are at.” Conversely, data can assist where not to place our collective efforts and re-direct to other areas of greater impact and actionability. This is the embodiment of population health. Our goals are to partner in ways which bring service to the care arena in ways we all can get closer to the Quadruple Aim in medical care. Providers are using data analytics tools not only to treat patients’ current conditions but also to find patterns of variation in care and identifying patients who are at risk for readmissions. Our collaboration in this same arena will enhance these efforts rather than hinder them.

For providers without the resources or ability to build robust, enterprise-wide data infrastructures, collaborations with payers may be a solution. Payers have access to a copious amount of data, and some providers are beginning to realize the benefit of partnering with payers to share data on cost and quality. These partnerships often provide more data than an organization could gather on its own. One might wonder where we go from here. The answer is based on defining common goals. A term often used in conflict resolution theory is “superordinate.” A goal that is higher in calling and common to all parties is considered superordinate. Striving for this goal will resolve the friction or conflict and bring resolution.

Physician awareness of this new reality is reflected in a monograph from the American Association for Physician Leadership [AAPL-2015]. The overwhelming majority of respondents — 92 percent — agreed that reducing unnecessary care, which produces wasteful spending and is not evidence-based, is an issue of high or very high importance. From the Harvard Business Review, with the higher calling of medical practice, our goals are to work toward what brings us all toward the goals we all ordain: making health care better for patients. Clinical, financial, and operational stakeholders can rally around this battle cry. As the article points out, these are not one-time projects, but really a long-term paradigm shift in the payer-provider relationship.

The goal of engaging the next generation of physicians is to develop partnerships that are ongoing and truly collaborative rather than based on one-off improvement projects. The continuous collaboration paradigm promotes teamwork, increases alignment and creates efficiencies that one-time efforts cannot achieve. The Sanford Health Plan outlook is for enhanced physician and member engagement in the collaborative IQ necessary to assist bringing data-driven, medical evidenced, high-quality care to our citizens. This integration cannot happen without the leadership of the physicians and care teams we are allied with. Now you know some of my superordinate goals.

Back to the question. Are we at the tipping point that this needs to be done? Many will ponder the question and different answers will abound. To me, the answer is it doesn’t matter, as aligning for the superordinate goals are most important. What’s your superordinate goal?

“Actionable data: The value-based tipping point and superordinate goals”

By: Timothy P. Donelan, MD

Timothy P. Donelan MD
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 sometimes only — resource sought out for 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 listing 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, as well as screening tools for anxiety, ADHD and bipolar disorder.

Quick Reference Behavioral Health Cards are available for the following regions:

- Iowa
- Minnesota
- North Dakota
- South Dakota
  - Southeast
  - Northeast
  - East-central
  - South-central
  - Central
  - North-central
  - Southwest
  - Northwest

Sanford Health Plan provides the following services:

- Antidepressant member education letters to people who have started antidepressant medication and missed a refill.
- Contact by a health plan life advocate upon a member’s discharge from an inpatient hospital or other facility for mental health or substance abuse.
  - Ensures that follow-up appointments are arranged and prescriptions are properly filled.
- EAP program for participating employer groups to assist managing utilization of behavioral health services.

Quick Reference Behavioral Health Cards or other tools are available:

Website: www.sanfordhealthplan.com
Phone: (605) 328-6877 or (800) 601-5086
Email: providerrelations@sanfordhealth.org
HEDIS® Report 2017

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 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.

Additional information on these programs is available on our mySanfordHealthPlan web portal. Please also watch for more communications coming in the future with tips for improving HEDIS® performance measure scores.

<table>
<thead>
<tr>
<th>HEDIS® 2017 Commercial HMO Rates</th>
<th>HEDIS® 2015</th>
<th>HEDIS® 2016</th>
<th>HEDIS® 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotic Utilization</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (Not prescribed antibiotics)</td>
<td>81.87%</td>
<td>77.53%</td>
<td>81.84%</td>
</tr>
<tr>
<td>Appropriate Testing for Children with Pharyngitis (Prescribed antibiotic and received strep test)</td>
<td>76.42%</td>
<td>77.29%</td>
<td>66.80%</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Appropriate avoidance of antibiotics)</td>
<td>14.96%</td>
<td>16.84%</td>
<td>19.68%</td>
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<tr>
<td><strong>Screenings</strong></td>
<td></td>
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<tr>
<td>Breast Cancer Screening (Ages 50-74 – due to the changes in age range in this measure, it is not comparable to prior rates)</td>
<td>77.46%</td>
<td>77.15%</td>
<td>75.68%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (Ages 21-64 - due to the changes in this measure criteria, it is not comparable to prior rates)</td>
<td>72.63%</td>
<td>72.16%</td>
<td>69.85%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (Ages 50-75) (*Actual rate was 60.26%)</td>
<td>64.54%*</td>
<td>63.42%</td>
<td>65.89%</td>
</tr>
<tr>
<td>Chlamydia Screening (Ages 16 to 24)</td>
<td>30.38%</td>
<td>30.28%</td>
<td>31.47%</td>
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<tr>
<td><strong>Health Management Programs</strong></td>
<td></td>
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<tr>
<td>Comprehensive Diabetes Care (Ages 18-75)</td>
<td></td>
<td></td>
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<tr>
<td>HbA1c Testing (*Actual rate was 94.71%)</td>
<td>94.89%*</td>
<td>96.90%</td>
<td>94.16%</td>
</tr>
<tr>
<td>Good HbA1c Control (&lt;7.0%) (*Actual rate was 44.62%)</td>
<td>46.05%</td>
<td>44.52%</td>
<td>43.81%</td>
</tr>
<tr>
<td>Eye Exam (*Actual rate was 44.62%)</td>
<td>46.05%</td>
<td>44.52%</td>
<td>43.81%</td>
</tr>
<tr>
<td>Monitoring Nephropathy (Nephropathy tx, microalbumin, + macroalbumin, ACEI/ARB)</td>
<td>89.96%</td>
<td>93.25%</td>
<td>92.70%</td>
</tr>
<tr>
<td>Blood Pressure Control (&lt;140/80) (*Actual rate was 79.01%)</td>
<td>79.20%*</td>
<td>82.12%</td>
<td>85.58%</td>
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<tr>
<td>Statin Therapy for Patients with Diabetes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Received Statin Therapy: Total</td>
<td></td>
<td></td>
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<tr>
<td>Statin Adherence 80%: Total</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Controlling High Blood Pressure (Ages 18-85) (Not trendable prior to HEDIS 2015 due to spec changes)</td>
<td>75.99%</td>
<td>80.51%</td>
<td>81.48%</td>
</tr>
<tr>
<td>Persistence of Beta Blocker Treatment After a Heart Attack</td>
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</table>
| Sanford Health Plan has numerous health management programs and other quality improvement activities currently in place, which focus activities on practitioners as well as members.
1. **Antibiotic Utilization** – HEDIS® measures the avoidance of antibiotic treatment in adults with acute bronchitis. These patients should generally not receive an antibiotic unless they have a bacterial infection or a co-morbid condition. If the member does have a bacterial infection or co-morbid condition, please make sure to include the appropriate diagnosis code on the claim. Members with co-morbidities are not included in this measure’s assessment of avoidance of antibiotic treatment.

2. **Cancer Screenings** – Please refer to our Preventive Health Guidelines for details on how the screenings are covered per plan type, which includes the factors of age and frequency of coverage. Please encourage your patients in the appropriate age groups to take advantage of these preventive services.

3. **Chlamydia Screening** – It may be difficult to start the conversation with your female patients about sexually transmitted diseases, but the discussion needs to happen. Women between the ages of 18 and 24 who come to you for an annual examination should be screened for chlamydia. If a pelvic exam is not performed, urine tests are available.

4. **Diabetic Eye Exams** – As you are aware, retinopathy is one of the most devastating complications of diabetes. Ask your diabetic patients whether they have had an annual diabetic eye exam and document the exam, results and eye care provider information in the patient’s record. If the patient has not completed their annual eye exam, please encourage them to receive proper eye care and remind them the annual retinal or dilated eye exam is a covered medical benefit for health plan members with diabetes. Members can contact customer service for coverage information.
Physician burnout takes toll, solutions studied

The health care environment — with its packed work days, demanding pace, time pressures, and emotional intensity — can put physicians and other clinicians at high risk for burnout. Burnout is a long-term stress reaction marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment.

In recent years, the rising prevalence of burnout among clinicians — over 50 percent in some studies — has led to questions about how it affects access to care, patient safety and care quality. Burned-out doctors are more likely to leave practice, which reduces patients’ access to, and continuity of, care. Burnout can also threaten patient safety and care quality when depersonalization leads to poor interactions with patients and when burned-out physicians suffer from impaired attention, memory and executive function.

Researchers surveyed 422 family physicians and general internists who worked in 119 ambulatory care clinics and surveyed 1,795 patients from these clinics and reviewed their medical records for information on care quality and medical errors. More than half of the physicians reported experiencing time pressures when conducting physical examinations. Nearly a third felt they needed at least 50 percent more time than was allotted for this patient care function.

In addition, nearly a quarter said they needed at least 50 percent more time for follow-up appointments.

Work conditions, such as time pressure, chaotic environments, low control over work pace, and unfavorable organizational culture, were strongly associated with physicians’ feelings of dissatisfaction, stress, burnout and intent to leave the practice.

However, physicians’ reactions to these work conditions were not consistently associated with quality of patient care. The investigators’ interpretation was that, although physicians are affected by work conditions, their reactions do not translate into poorer quality care because the physicians act as buffers between the work environment and patient care. When lower quality care was seen, the investigators found it was the organization that burned doctors out leading to lower quality care, rather than the burned-out doctors themselves.

The MEMO study also found that the hope that electronic health records (EHRs) in the workplace would reduce stress has not been realized; in fact, implementation of an EHR can contribute to burnout. Researchers found practices that implemented electronic health records saw in increase in stress as EHR use matured and then a decrease, but stress did not return to the baseline. Additionally, fully mature EHR systems, especially with shorter visits, were associated with physician stress, burnout and intent to leave the practice. Another study, MS Squared — Minimizing Stress, Maximizing Success of the EHR (AHRQ grant HS22065) — of 400 doctors is currently identifying the amount of EHR-related burnout in practices, EHR-related stressors, and solutions for mitigating this stress.

“Issues of work conditions, clinician reactions (including satisfaction and burnout), and patient outcomes over the past 15 years has allowed us to make concrete recommendations to health systems on how to build healthier workplaces for providers and patients.”

— Mark Linzer, M.D., Hennepin County Medical Center, Minneapolis, MN

Since 2001, The Agency for Healthcare Research & Quality (AHRQ) has been investing in major projects that examine the effects of working conditions on health care professionals ability to keep patients safe while providing high-quality care. This research is part of the agency’s ongoing efforts to develop evidence-based information aimed at improving the quality of the U.S. health care system by making care safer for patients and improving working conditions for clinicians. One AHRQ-funded project, the MEMO — Minimizing Error, Maximizing Outcome — Study (AHRQ grant HS11955), found that more than half of primary care physicians report feeling stressed because of time pressures and other work conditions.

Researchers have been studying the effects of working conditions on physicians’ reactions.

“Physician friendly” and “family friendly” organizational settings also seem to result in greater physician well-being, according to an AHRQ-funded study involving a national sample of 171,000 primary care doctors. Doctors also fare better in organizations where they are not compensated for individual productivity, are not under time stress, have more control over clinical issues and are able to balance family life with their work. (AHRQ grant HS00032)

INTERVENTIONS:
AHRQ-funded research led to a new measure of burnout and the identification of several interventions that can potentially mitigate it. AHRQ grantee Mark Linzer, M.D., FACP, of Hennepin County Medical Center (HCMC) in Minneapolis, Minn., created the Mini Z Burnout Survey that lets practices take a quick temperature of how much stress and burnout they are experiencing and what might be causing it. Linzer’s work is included in the American Medical Association’s Steps Forward evidence-based module on burnout prevention for doctors and practices, created by HCMC, the American Medical Association, and the
The AHRQ-funded Healthy Work Place Study (AHRQ grant HS18160), a cluster randomized trial of 166 physicians, nurse practitioners, and physician assistants in 34 primary care clinics, had clinicians select from a list of interventions from three categories that addressed improving communication, changing workflow, or addressing clinician concerns via quality improvement projects. Each of these categories of interventions led to improvements in some clinician outcomes, suggesting that a range of interventions that directly address clinicians’ perceptions and concerns can be effective.

Some of the interventions on the list included:

- Scheduling monthly provider meetings focused on work-life issues or clinical topics after surveying staff members on which topics to address.
- Enhancing team functioning through diabetes and depression screening quality improvement projects to engage office staff, enhance teamwork and reduce the pressure on physicians to be responsible for all aspects of care.
- Having medical assistants enter patient data into electronic health records, track forms and send faxes to give more face-to-face time with patients.

Implementing a Patient-Centered Medical Home can also improve physician satisfaction and reduce burnout. An AHRQ study of 26 clinics in a health system found that reducing the physician panel size to 1,800 patients, increasing flexibility for longer patient visits, reducing the number of face-to-face visits per day, and increasing care team staffing improved work satisfaction and burnout rates. The percentage of staff reporting that they were “extremely satisfied” with their workplace increased from 38.5 percent at baseline to 42.2 percent at follow up, and rates of reported burnout decreased from 32.7 to 25.8 percent after implementing the Patient-Centered Medical Home. (AHRQ grant HS19129)

Additional interventions that need further testing but may be able to assist in reducing burnout are:

- Creating standing order sets
- Providing responsive information technology support
- Reducing required activities.
- Providing time in the workday and workflow to complete required documentation tasks and enter data into the electronic health record
- Offering flexible or part-time work schedules
- Having leaders model and support work-home balance
- Hiring floating clinicians to cover unexpected leave
- Building workplace teams that address workflow and quality measures
- Ensuring values align between clinicians and leaders

CONCLUSION:
Burnout takes a toll on physicians, their patients and their practices. Short visits, complicated patients, lack of control, electronic health record stress, and poor work-home balance can lead to physicians leaving practices they once loved, poor patient outcomes and shortages in primary care physicians. AHRQ’s extensive body of research findings clearly demonstrate what causes burnout and offers a starting point for interventions on how it can be reversed.

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Medical record documentation and audit results

Each year, we review medical charts for our HEDIS® reporting, checking if general standards are met. For 2017, the three standards that had the lowest compliance rates:

- Personal biographical data that includes address, home and work telephone numbers.
- Appropriate notation concerning the use of cigarettes, alcohol, and substances in people who are 14 years and older.
- Immunization records for children are up to date or an appropriate history has been made in the medical record for adults.

Why is complete medical record documentation important?
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.

Sanford clinics and non-Sanford clinics are included in this review. There are a total of 17 elements that clinics must be in compliance with, and we would like to share with you the three elements that had the lowest compliance rates:

- Personal biographical data including the address, home and work telephone numbers.
- Medication allergies and adverse reactions and prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.

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.

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.
Tools to reduce hospital-acquired conditions

The Agency for Healthcare Research & Quality has a listing of tools that could be used to reduce hospital-acquired conditions. Use these tools to help protect your patients while hospitalized. Hospital-acquired conditions (HACs) are conditions that a patient develops while in the hospital being treated for something else. These conditions cause harm to patients. Hospitals and others working with the Partnership for Patients are focused on reducing specific HACs that occur frequently, can cause significant harm, and are often preventable based on existing evidence.

To reduce these HACs and other adverse events in hospitals frontline clinicians, and others use many of the methods, tools, and resources listed below that AHRQ has developed.

**Adverse drug events:** [Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)


**Injuries and falls from immobility:** [Preventing Falls in Hospitals](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)

**Obstetrical adverse events:** [AHRQ Safety Program for Perinatal Care](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)

**Pressure Ulcers:** [Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)

**Surgical site infections:** [AHRQ Safety Program for Surgery](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)

**Venous Thromboembolism (VTE):** [Preventing Hospital-Associated Venous Thromboembolism](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)


Frontline clinical teams are also using these AHRQ resources to help build the foundation to make care safer and tackle specific HACs, including healthcare-associated infections:

- [Core Comprehensive Unit-based Safety Program Toolkit](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)
- [TeamSTEPPS®](http://www.ahrq.gov/professionals/quality-patient-safety/hac/tools.html)

Specialty referral alternative assistance

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, 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 feel free to refer that patient to Sanford Health Plan Customer Service at (800) 752-5863.

Formulary changes 7/1/17

Additions:
- Dupixent
- Tymlos
- Xermelo
- Xultophy
- Epinephrine auto injector (Authorized generics for Epipen and Adrenaclick)

Removals:
- Epipen
- Epipen Jr.